SERFF Tracking Number:	*HCCH-126714556*	*State:*	*Arkansas*
Filing Company:	*HCC Life Insurance Company*	*State Tracking Number:*	*46167*
Company Tracking Number:	*PPACA HCCL MSL-2010*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Medical Stop Loss*		
Project Name/Number:	*/*		

Filing at a Glance

Company: HCC Life Insurance Company

Product Name: Medical Stop Loss	SERFF Tr Num: HCCH-126714556	State: Arkansas
TOI: H12 Health - Excess/Stop Loss	SERFF Status: Closed-Approved-Closed	State Tr Num: 46167
Sub-TOI: H12.004 Self-Funded Health Plan	Co Tr Num: PPACA HCCL MSL-2010	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Brad Long, Misty Pagelsen	Disposition Date: 07/21/2010
	Date Submitted: 07/09/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: This filing was submitted to HCC Life's state of domicile, Indiana, on July 7, 2010 and is pending approval.
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 07/21/2010	Explanation for Other Group Market Type:
	State Status Changed: 07/21/2010
Deemer Date:	Created By: Misty Pagelsen
Submitted By: Misty Pagelsen	Corresponding Filing Tracking Number:

Filing Description:

HCC Life Insurance Company (“HCC Life”) writes medical stop loss insurance to employer groups that self-fund their employee health benefit plans. With the passage of the Patient Protection and Affordable Care Act (“PPACA”), each of our self-funded clients have had to make changes to their plan of benefits and HCC Life is having to alter our stop loss forms to accommodate these changes. These two new medical stop loss policy forms are intended to replace two HCC Life’s stop loss forms previously approved in your state. Although stop loss forms were not addressed by the NAIC’s

SERFF Tracking Number:	*HCCH-126714556*	*State:*	*Arkansas*
Filing Company:	*HCC Life Insurance Company*	*State Tracking Number:*	*46167*
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Product Name:	*Medical Stop Loss*		
Project Name/Number:	*/*		

Speed to Market Task Force in their recent efforts to accommodate health form changes due to PPACA, we would very much appreciate the Department's expedited handling of our form updates. Our self-funded policyholders are required to change their plans to comply with PPACA. Their stop loss coverage needs to be changed as well, so the Department's cooperation in handing this filing as quickly as possible will be helpful. HCC Life will immediately begin using these forms upon approval.

Company and Contact

Filing Contact Information

Misty Pagelsen,
225 TownPark Drive
Suite 145
Kennesaw, GA 30144

mpagelsen@hcclife.com
770-693-6455 [Phone]

Filing Company Information

HCC Life Insurance Company
225 TownPark Dr., NW
Suite 145
Kennesaw , GA 30144-5885
(770) 693-6441 ext. [Phone]

CoCode: 92711
Group Code:
Group Name:
FEIN Number: 35-1817054

State of Domicile: Indiana
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	There is a $50.00 per form fee and there are two (2) forms being submitted with this filing.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
HCC Life Insurance Company	$100.00	07/09/2010	37843956

SERFF Tracking Number:	*HCCH-126714556*	*State:*	*Arkansas*
Filing Company:	*HCC Life Insurance Company*	*State Tracking Number:*	*46167*
Company Tracking Number:	*PPACA HCCL MSL-2010*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Medical Stop Loss*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/21/2010	07/21/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	07/20/2010	07/20/2010	Misty Pagelsen	07/20/2010	07/20/2010

SERFF Tracking Number:	*HCCH-126714556*	*State:*	*Arkansas*
Filing Company:	*HCC Life Insurance Company*	*State Tracking Number:*	*46167*
Company Tracking Number:	*PPACA HCCL MSL-2010*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Medical Stop Loss*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 07/21/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*HCCH-126714556*	*State:*	*Arkansas*
Filing Company:	*HCC Life Insurance Company*	*State Tracking Number:*	*46167*
Company Tracking Number:	*PPACA HCCL MSL-2010*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Medical Stop Loss*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document *(revised)*	Application	Approved-Closed	Yes
Supporting Document	Application	Replaced	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Filing Cover Letter	Approved-Closed	Yes
Supporting Document	HCCL MSL-2010 Redline	Approved-Closed	Yes
Form	Medical Stop Loss Policy	Approved-Closed	Yes
Form *(revised)*	Medical Stop Loss Application	Approved-Closed	Yes
Form	Medical Stop Loss Application	Replaced	Yes

SERFF Tracking Number:	*HCCH-126714556*	*State:*	*Arkansas*
Filing Company:	*HCC Life Insurance Company*	*State Tracking Number:*	*46167*
Company Tracking Number:	*PPACA HCCL MSL-2010*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Medical Stop Loss*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/20/2010
Submitted Date	07/20/2010
Respond By Date	

Dear Misty Pagelsen,

This will acknowledge receipt of the captioned filing.

Objection 1

- Medical Stop Loss Application , HCCL MSL-2010 APP (Form)

Comment:

Stop Loss applications must contain the following notice as outlined under our Bulletin 6-2008:

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*HCCH-126714556*	*State:*	*Arkansas*
Filing Company:	*HCC Life Insurance Company*	*State Tracking Number:*	*46167*
Company Tracking Number:	*PPACA HCCL MSL-2010*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Medical Stop Loss*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/20/2010
Submitted Date	07/20/2010

Dear Rosalind Minor,

Comments:

Response 1

Comments: The application has been changed to a state specific application to include the notice from Bulletin 6-2008. There is a final application included on the forms tab and a redline application included on the supporting documents tab.

Related Objection 1

Applies To:

- Medical Stop Loss Application , HCCL MSL-2010 APP (Form)

Comment:

Stop Loss applications must contain the following notice as outlined under our Bulletin 6-2008:

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Application

Comment: HCC Life is filing a new application with this filing to replace the previously approved application on file with the State. Attached is the red line of the application attached on the form schedule tab. This application is state specific to include the notice from Bulletin 6-2008.

SERFF Tracking Number:	*HCCH-126714556*	*State:*	*Arkansas*
Filing Company:	*HCC Life Insurance Company*	*State Tracking Number:*	*46167*
Company Tracking Number:	*PPACA HCCL MSL-2010*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Medical Stop Loss*		
Project Name/Number:	*/*		

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Medical Stop Loss Application	HCCL MSL-2010 APP		Application/Enrollment Form	Revised	34701		HCCL MSL-2010 APP AR - Final.pdf
Previous Version							
Medical Stop Loss Application	*HCCL MSL-2010 APP*		*Application/Enrollment Form*	*Revised*	*34701*		HCCL MSL-2010 APP - final.pdf

No Rate/Rule Schedule items changed.

It is the hope off HCC Life that all concerns with this filing have been addressed to the satisfication of the State. Thank you in advance for your review of this filing.

Sincerely,
Brad Long, Misty Pagelsen

SERFF Tracking Number:	*HCCH-126714556*	*State:*	*Arkansas*
Filing Company:	*HCC Life Insurance Company*	*State Tracking Number:*	*46167*
Company Tracking Number:	*PPACA HCCL MSL-2010*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Medical Stop Loss*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: HCCL MSL-2010

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/21/2010	HCCL MSL-2010	Policy/Contract/Fraternal Certificate	Medical Stop Loss Policy	Revised	Replaced Form #: HCCL MSL-2007 Previous Filing #: 34701	49.100	HCCL MSL-2010 - final.pdf
Approved-Closed 07/21/2010	HCCL MSL-2010 APP	Application/Enrollment Form	Medical Stop Loss Application	Revised	Replaced Form #: HCCL MSL-2007 APP Previous Filing #: 34701		HCCL MSL-2010 APP AR - Final.pdf

HCC LIFE INSURANCE COMPANY
225 Town Park Drive, Suite 145
Kennesaw, Georgia 30144
1-800 447-0460

STOP LOSS POLICY

THIS IS A LEGAL CONTRACT - PLEASE READ IT CAREFULLY

Policy Number:

Policyholder:

Principal Address:

Designated Plan Supervisor (or TPA):

This Policy is issued in consideration of Your Application, Your Plan Document, Your Disclosure Statement and the payment of premiums. The aforementioned documents combine to form this Policy.

The effective date of this Policy is 12:01 a.m., at Your address and the expiration date of this Policy is 11:59 p.m., as shown below at Your principal address.

Effective Date:

Expiration Date:

This Policy is issued by Us as of the Effective Date, but is not valid unless countersigned by Our duly authorized representative.

Jurisdiction of Issue: [Any State]

This policy is governed by the laws of the jurisdiction of issue.

_____ _____

President Vice President and General Counsel

NON-PARTICIPATING INSURANCE

This is a reimbursement policy. You, or Your Plan Supervisor, are responsible for making benefit determinations under Your Employee Benefit Plan. We have no duty or authority to administer, settle, adjust, or provide advice regarding claims filed under Your Employee Benefit Plan.

TABLE OF CONTENTS

ARTICLE I. DEFINITIONS

When used in this Policy, the following terms will have the meanings as indicated below:

ANNUAL AGGREGATE DEDUCTIBLE. For any one Contract Period, (or any fraction thereof, if the Contract terminates during the Contract Period) the total of the number of Covered Single or Family units multiplied by its corresponding Monthly Aggregate Factor, applied each month that the Contract is in-force. In no instance shall the Annual Aggregate Deductible be less than the Minimum Annual Aggregate Deductible.

AGGREGATE CONTRACT PERIOD REIMBURSEMENT MAXIMUM. The maximum amount We will reimburse the Policyholder for Covered Expenses during each Contract Period under the terms of the Aggregate Stop Loss Insurance as shown on the Application.

AGGREGATE PERCENTAGE REIMBURSABLE. The percentage of Covered Expenses to be reimbursed that were Paid under the Employee Benefit Plan in excess of the Annual Aggregate Deductible.

COBRA BENEFICIARY. Any former Covered Person of the Employee Benefit Plan continuing participation under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments.

COMPANY. Company, We, Our, and Us refers to HCC Life Insurance Company.

COMPLETE CLAIMS HISTORY. All of the following for a minimum of 12 consecutive months immediately preceding the Policy Year:

1. Participant census, and
2. Eligibility information, and
3. Claims Experience, and
4. Large Claim Disclosures, and
5. Details of any condition shown on the Trigger Diagnosis List in the Disclosure Statement.

CONTRACT. All of the following:

1. The Application, and
2. This Policy and any endorsements to it, and
3. The Policyholder's Plan Document.

CONTRACT BASIS. The form of coverage shown on the Application that was selected by the Policyholder. The Contract Basis shall be considered in determining what Covered Expenses will be reimbursed by Us.

CONTRACT MONTH. A period of one-month that begins on:

1. The effective date of the Policy, or
2. The same day of each following month during the Contract Period.

CONTRACT PERIOD. The period of time shown on the Application during which the Policyholder is covered for Aggregate and / or Specific Stop Loss Insurance.

COST CONTAINMENT PROGRAM. A program designed to reduce or control the cost of providing Plan Benefits to participants of the Employee Benefit Plan.

COVERED EXPENSES. Plan Benefits incurred by a Covered Person (or Covered Family):

1. For which benefits are Paid by the Policyholder under the Employee Benefit Plan, and
2. Which are not in excess of the Reasonable and Customary Charge for those services, and
3. Which are Medically Necessary for the treatment of an illness or injury or for any preventative care covered by the Employee Benefit Plan, and
4. Which are reimbursable under this policy subject to its terms, deductible(s), limitations and exclusions.

Plan Benefits provided by the Employee Benefit Plan that are specifically excluded by this Policy are not considered Covered Expenses. Covered Expenses shall not include any expenses which are not reimbursable under this Policy, such as:

1. The expenses related to processing claim payment, or
2. PPO discounts, network or negotiated discounts, and other reductions from billed charges, whether or not they were actually deducted from Plan Benefits, or
3. Salaries paid to any individual, or
4. Plan Supervisor's fees, or
5. Litigation expenses, or
6. Premiums paid for coverage under this Policy.

COVERED FAMILY. The Covered Person and his or her dependents covered under the Employee Benefit Plan.

COVERED PERSON. If so indicated on the Application, an individual covered under the Employee Benefit Plan. This includes:

1. Legally employed covered employees, and
2. Covered dependents, and
3. Participating COBRA Beneficiaries, and
4. Retirees.

COVERED UNITS. A Covered Person, a Covered Family, or such other defined unit as agreed upon between You and Us in writing.

DEDUCTIBLE. The amount of Covered Expenses You must pay before Aggregate Stop Loss Insurance and / or Specific Stop Loss Insurance benefits become reimbursable. The Deductible(s) is / are shown on the Application issued to You. See also:

1. Annual Aggregate Deductible, and
2. Specific Deductible, and
3. Specific Family Deductible.

ELIGIBLE. Eligible under the Employee Benefit Plan.

EMPLOYEE BENEFIT PLAN. The medical benefits You have agreed to provide under a plan of benefits for Your Eligible employees and their Eligible dependents, whether or not it is subject to the Employee Retirement Income Security Act of 1974, as is or as may be amended.

EXPERIMENTAL AND INVESTIGATIVE. A drug, device or medical treatment or procedure is Experimental or Investigative:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, or
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials or under study to determine its:
    a. Maximum tolerated dose, or
    b. Toxicity, or
    c. Safety, or
    d. Efficacy, or
    e. Efficacy as compared with the standard means of treatment or diagnosis, or
3. If reliable evidence shows that the consensus among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
    a. Maximum tolerated dose, or
    b. Toxicity, or
    c. Safety, or
    d. Efficacy, or
    e. Efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative peer reviewed medical and scientific literature, or
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure, or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

INCURRED. The date on which medical care or a service or supply is provided to a Covered Person for Plan Benefits under the Employee Benefit Plan for which a charge results.

LARGE CLAIM DISCLOSURE. You, with the assistance of Your Plan Supervisor, agree to disclose to us any known or potential shock losses. Shock Losses are:

1. Injuries, and
2. Illnesses, and
3. Diseases, and
4. Diagnoses, and
5. Any condition listed on the Trigger Diagnosis list, and
6. Other losses of the type, which are reasonably expected or are likely to result in significant medical expense or liability.

LOSS LIMIT. The maximum amount of Covered Expenses Incurred by each Covered Person (or Covered Family), which can be used to satisfy the Annual Aggregate Deductible. This amount is shown in the Application. The maximum allowable amount of Covered Expenses by a Covered Person who has been assigned a Separate Individual Specific Deductible will be the specified amount as shown under the Loss Limit on the Application, regardless of that Covered Person's Separate Individual Specific Deductible.

MEDICALLY NECESSARY. A procedure, treatment, service, supply, equipment, drug or medicine that is:

1. Deemed appropriate, essential and is recommended for the diagnosis or treatment of the Covered Person's symptoms by a licensed physician, dentist or other medical practitioner who is practicing within the scope of his or her license and specialty or primary area of practice, and
2. Within the scope, duration and intensity of that level of care which is required to provide safe, adequate and appropriate diagnosis or treatment, and
3. Prescribed in accordance with the generally accepted, current professional medical practice and is not considered Experimental or Investigative.

MINIMUM ANNUAL AGGREGATE DEDUCTIBLE. For each Contract Period, the number of Contract Months times the Monthly Aggregate Factor times the number of Covered Units. Covered Units shall be based on the first month's enrollment or the quoted enrollment whichever is greater. The Minimum Annual Aggregate Deductible as shown on the Application is based on the quoted enrollment and it is subject to change if the first month's enrollment is greater.

MONTHLY AGGREGATE DEDUCTIBLE. The Monthly Aggregate Deductible is determined for each Contract Month by multiplying the number of Covered Units for that month by the applicable Monthly Aggregate Factor(s) shown on the Application.

MONTHLY AGGREGATE FACTOR. The amount specified in the Application.

MONTHLY SPECIFIC PREMIUM RATES. The amounts specified in the Application.

NET PAID CLAIMS. The sum of Covered Expenses Paid during the Policy Year by You less the sum of all amounts paid by You that exceeds the Loss Limit of any Covered Person(s).

ORIGINAL EFFECTIVE DATE. The first day of the Contract Period of Your initial Stop Loss Policy with Us subject to any Run-In Period as shown on the Application. If coverage has not been continuous with Us, then the Original Effective Date shall be the first day of the most recent continuous coverage.

PAY, PAID, PAYMENT. Charges that, as of the dates shown in the Contract Basis, are:

1. Covered and payable under your Employee Benefit Plan, and
2. Have been adjudicated and approved, and
3. A check or draft for remuneration is issued and deposited in the U.S. Mail, or other similar conveyance or is otherwise delivered to the payee, and
4. Sufficient funds are on deposit the date the check or draft is issued.

Our reimbursements will not be made until all of these conditions are satisfied. Checks or drafts that are returned to the payor unpaid for any reason will not be considered Paid.

PLAN BENEFITS. The medical expense benefits to which Covered Persons become entitled under the Employee Benefit Plan during the Policy Year which are:

1. Incurred after the effective date of this Policy or the first date of the Run-In Period, and
2. Incurred while this Policy is in-force, and
3. Paid during the Policy Year or before the end of the Run-Out Period.

Plan Benefits do not include:

1. Deductibles, or
2. Co-insurance amounts, or

3. Interest, or
4. Expenses, or
5. The amounts of any PPO discounts, network or negotiated discounts, or any other reductions to billed charges, whether or not they were actually deducted, and
6. Claims paid under an Employee Benefit Plan's discretionary clause or similar provision that would not otherwise be payable under the terms and conditions of the Employee Benefit Plan, and
7. Claims that are not covered under the terms and conditions of the Employee Benefit Plan or that are reimbursable from any other source.

An Employee Benefit Plan expense is incurred at the time the serviced is rendered or the supply is provided.

PLAN DOCUMENT. The written document evidencing Your Employee Benefit Plan including any amendments. You will provide Us with a copy of Your Plan Document that is in effect as of the Policy effective date. Amendments are subject to Article VI, Item D and Article VII, Item A.3.a of this Policy. We will provide written confirmation of receipt of this Plan Document. The Plan Document does not waive of any provisions of this Policy.

PLAN SUPERVISOR (TPA). The person or entity selected by the Plan Sponsor and approved by Us to perform administrative services for the Employee Benefit Plan, including payment of claims.

POLICY YEAR. The period beginning on the effective date and ending on the expiration date as shown on the face page of this Policy, or the actual period of time during which the Policy is in force if the Policy terminates prior to the expiration date.

POLICYHOLDER. Employer, Insured, You, Your or Plan Sponsor.

REASONABLE AND CUSTOMARY CHARGE. Charges for medical expenses, including but not limited to, physician services, hospital supplies, hospital bed rates, drugs, ancillary services and durable medical equipment usually made by such providers in the same geographical area using nationally and regionally adjusted data.

RUN-IN PERIOD. The period of time as defined under the Contract Basis on the Application during which claims for Plan Benefits may be Incurred provided they are Paid during the Contract Period.

RUN-OUT PERIOD. The period of time as defined under the Contract Basis on the Application during which claims for Plan Benefits may be Paid provided they were Incurred during the Contract Period.

SPECIFIC CONTRACT PERIOD REIMBURSEMENT MAXIMUM. The maximum amount of Covered Expenses We will reimburse You in each Contract Period for any one Covered Person (or Covered Family). This amount shall not exceed the amount shown as the Specific Contract Period Reimbursement Maximum on Your Application, or any maximum benefit amount or limit defined in Your Employee Benefit Plan, whichever is less.

SPECIFIC DEDUCTIBLE. If a Specific Deductible is shown on the Application, this is the amount of Covered Expenses that must be Paid by the Employee Benefit Plan for any Covered Person before Specific Stop Loss Insurance benefits are reimbursable under the Policy. It applies separately for each Policy Year and will be determined annually by Us.

SPECIFIC FAMILY DEDUCTIBLE. If a Specific Deductible is shown on the Application per a Covered Family, this is the amount of Covered Expenses which must be Paid by the Employee Benefit Plan for any Covered Family member or combination of Covered Family members before Specific Stop Loss Insurance benefits are reimbursable under the Policy. It applies separately for each Policy Year and will be determined annually by Us.

SPECIFIC PERCENTAGE REIMBURSABLE. The percentage of Covered Expenses to be reimbursed that were Paid under the Employee Benefit Plan in excess of the Specific Deductible.

ARTICLE II. SPECIFIC STOP LOSS INSURANCE

A. Subject to the terms, conditions and limitations of this Policy, We will reimburse You for Covered Expenses Paid in excess of the Specific Deductible (or Specific Family Deductible).

B. We will not reimburse you for any amounts after the Specific Contract Period Reimbursement Maximum has been reached.

C. We will not reimburse You for Plan Benefits Incurred after the Policy's expiration date.

D. If the Policy terminates before the expiration date, Plan Benefits paid after the date of termination will not be eligible for reimbursement.

E. Plan Benefits Paid by You which have been reimbursed by Us under Your Aggregate Stop Loss Insurance or by another insurance company or reinsurance company will not be used to:

1. Satisfy the Specific Deductible (or the Specific Family Deductible), or
2. Compute Specific Stop Loss Insurance benefits payable to You.

F. The Monthly Specific Premium Rates shown on the Application apply only to the Policy Year shown therein. New Monthly Specific Premium Rates will be furnished for each new Policy Year and will be shown on a new Application provided for each Policy Year.

ARTICLE III. AGGREGATE STOP LOSS INSURANCE

A. Subject to the terms, conditions and limitations of this Policy, We will reimburse You for Eligible Covered Expenses Paid, less:

1. The Annual Aggregate Deductible or the Minimum Annual Aggregate Deductible, whichever is greater, and
2. Specific Stop Loss reimbursements due or paid to You, and
3. Any amounts paid by you that exceeds the Loss Limit for any Covered Person (or Covered Family).

B. We will not reimburse you for any amounts after the Aggregate Contract Period Reimbursement Maximum has been reached.

C. We will not reimburse You for Plan Benefits Incurred after the Policy's expiration date.

D. If the Policy terminates before the expiration date, any Plan Benefits paid after the date of termination will not be eligible for reimbursement.

E. Plan Benefits Paid by You which have been reimbursed by Us under Your Specific Stop Loss Insurance, by another insurance company or reinsurance company will not be used to:

1. Satisfy the Annual Aggregate Deductible or the Minimum Annual Aggregate Deductible, or
2. Compute the Aggregate Stop Loss Insurance benefits payable to You.

F. Plan Benefits Paid by You which exceed the Specific Contract Period Reimbursement Maximum for Specific Stop Loss Insurance as shown on the Application will not be used to:

1. Satisfy the Annual Aggregate Deductible or Minimum Annual Aggregate Deductible, or
2. Compute the Aggregate Stop Loss Insurance benefits payable to You.

G. Reimbursement for Aggregate Stop Loss Insurance for any Covered Person (or Covered Family) will be limited to an amount not to exceed the Specific Deductible (or Specific Family Deductible) or the Loss Limit, whichever is less, as set forth in the Application.

H. The Monthly Aggregate Factor(s) shown on the Application apply only to the Policy Year shown therein. New Monthly Aggregate Factors will be furnished for each new Policy Year and will be shown on a new Application provided for each Policy Year.

I. The Monthly Aggregate Deductible cannot be reduced by more than 10% per month if the number of Covered Persons decreases for any reason. If any Covered Persons are absent from work due to a strike, lockout, or work stoppage during any Contract Month, the number of Covered Persons will remain at the same level as for the Contract Month preceding the disruption.

ARTICLE IV. CLAIMS UNDER THE POLICY

A. Specific Claims

1. We will reimburse You for Specific Stop Loss Insurance, subject to the terms, conditions and limitations of this Policy, only after We receive a request for reimbursement with complete claim information.

2. The following documentation is required to file a Specific Stop Loss claim:

   a. *Specific Claim Notification / Initial Filing form*, and
   b. A copy of the employee's enrollment card, including the employee's hire date and the original effective date, and
   c. A copy of the Plan Supervisor's claim form if the claim is for a dependent, and
   d. Complete details regarding eligibility, and if applicable, information regarding work status, pre-existing / HIPAA documentation, subrogation, Coordination of Benefits, provider discounts and COBRA, including a copy of the COBRA election form and COBRA payment verification for all months, and
   e. Copies of *Explanations of Benefits* attached to the corresponding itemized bills, and
   f. Check copies, if not part of an *Explanation of Benefits*, and
   g. Completion of the *Specific Supplemental Claim Request* portion of the claim form if applicable, and
   h. Miscellaneous information as applicable, including but not limited to:
      i. Complete accident details, including how, when and where an accident may have occurred, and
      ii. Police reports for motor vehicle accidents or for services for which a law enforcement agency is involved, and
      iii. A *Subrogation and Right of Recovery Reimbursement Agreement* if charges were Incurred as a result of a third party liability, and
      iv. Coordination of benefits documentation, and
      v. PPO discount / repricing sheets, and
      vi. *Large Case Management Reports*, and
   i. Other documentation We may request.

3. [LATE CLAIMS: Any claim that is either submitted, or that remains incomplete, more than 90 days after the last date for which Plan Benefits can be reimbursed under the terms of the Policy will be denied, whether or not the delay has prejudiced Us. Your or Your Plan Supervisor's failure to file a complete claim in a timely manner may result in an adjustment of Our reimbursement to You to reflect any savings We could have obtained had a timely claim filing taken place pursuant to this provision.]

OR

[LATE CLAIMS: Satisfactory proof of loss must be provided to the Company within a reasonable amount of time after the 50% Notification or Large Claim Disclosure is received.]

Comment [b1]: For Incurred Contracts Basis only

4. [50% NOTIFICATION: You or Your Plan Supervisor must give notice to Us when the total amount of Plan Benefits Paid by You on a Covered Person equals or exceeds 50% of the Specific Deductible, or has the potential to exceed 50% of the Specific Deductible. Your failure to give prompt notice may result in an adjustment of Our reimbursement to You, if any, to reflect any savings We could have obtained had a prompt 50% Notification been given.]

OR

[50% NOTIFICATION: You or Your Plan Supervisor must give notice to Us when the total amount of Plan Benefits Paid by You on a Covered Person equals or exceeds 50% of the Specific Deductible, or has the potential to exceed 50% of the Specific Deductible. There is no specific coverage of a claim if written notice of the pending claim is not received by HCC Life within 12 months after the end of the Policy Year.]

Comment [b2]: For Incurred Contract Basis only

B. Aggregate Claims

1. We will reimburse You for Aggregate Stop Loss Insurance, subject to the terms, conditions and limitations of this Policy, only after We receive a request for reimbursement with Complete Claim History.

2. The following documentation is required to file an Aggregate Stop Loss claim:

   a. Completed *Year End Aggregate Claim Form*, and
   b. *Paid Claims Analysis report* indicating claimant's name, Incurred date, charged amount, Paid amount and Paid date, and
   c. Eligibility listing which identifies birth date, effective date, termination date and coverage type, and
   d. Proof of funding to include bank statements and/or deposit slips, and
   e. *Void & Refund report*, and
   f. *Benefit / Service Code report*, and
   g. *Aggregate Report* (Monthly Loss Summary Reports), and
   h. *Specific Report* showing which claimants have exceeded the Specific Deductible or Loss Limit, and
   i. Listing of payments made outside the Aggregate Stop Loss Insurance (i.e. Dental, Weekly Income, Vision, PPO fees capitated and, PCS Administrative Fees), and
   j. Check Register, and
   k. Outstanding overpayment and subrogation log, and
   l. Prescription invoices if Prescriptions are covered under the Aggregate Stop Loss Insurance, and
   m. Other documentation We may request.

   We may also request this information the month following the expiration date of the Policy to review for retroactive adjustments.

3. Any reimbursement payable by Us to You, under this article, will be paid after the end of the Contract Period, unless otherwise endorsed.

4. CLAIM FILING: You must file a request for reimbursement with Us on Our customary Notice / Proof of Loss form within 90 days after the end of the time specified for payment of claims under this Policy. Your failure to file a claim within 90 days will result in claim denial, whether or not the delay has prejudiced Us.

5. DETERMINATION OF THE ULTIMATE AGGREGATE CLAIM: You must submit a Proof of Loss within 90 days of the end of the Policy Year or Run-Out Period, whichever is later, showing the amount of all Plan Benefits Eligible under the Employee Benefit Plan and this Policy which You have Paid. These shall be compared to the greater of the Annual Aggregate Deductible or the Minimum Annual Aggregate Deductible. If the amount of Net Paid Claims eligible under this policy is greater than the appropriate Annual Aggregate Deductible, We will reimburse You for the amount of the excess.

C. All Claims

1. REIMBURSEMENT OF CLAIMS: Prior to making any reimbursement, We have the right to review each claim submitted to Us to determine if You are entitled to any reimbursement under this Policy. This review may include, but is not limited to, an on-site audit or requests for additional documentation. You warrant that You have Paid the providers of Plan Benefits for which reimbursement is sought.

2. SETTLEMENT OF PLAN CLAIMS: We have no duty or obligation to settle or adjust any claims for Plan Benefits filed under Your Employee Benefit Plan.

3. RIGHT OF RECOVERY. If You are entitled to recover from any party Plan Benefits Paid under the Employee Benefit Plan, such amounts cannot be used to satisfy either the Specific and / or Aggregate Deductibles. We also will not reimburse You for any Plan Benefit recovered from any party. If We have reimbursed You for all or part of a Plan Benefit and You recover any part of the Plan Benefit from any party, You must repay Us to the extent of Our reimbursement regardless of whether the policy is still in-force on the date of the recovery. You must reimburse Us first, and in full, before You receive any benefit of the recovery. We retain the right to employ our own independent counsel and You assign to us Your rights and the Employee Benefit Plan's rights to the extent of Our reimbursement(s) to You.

   In the event that You reimburse Us in the matter where Our designated counsel is not involved, Your repayment may be reduced by the reasonable and necessary expenses incurred in recovering from the third party.

   If You fail to reimburse Us for a valid claim for a Covered Expense against a third party, and We are required to reimburse You for such a Covered Expense, We shall be subrogated to Your rights to pursue the claim.

   Any amount We recover shall first be used to pay Our expenses of collection and then apply towards any amount that We reimbursed You under the policy. Any remaining amount will be paid to You.

   You are required to provide Us with such information as We request in order to protect Our right to reimbursement.

4. CLAIMS ELIGIBLE UNDER TWO CONTRACTS. If a claim for reimbursement can be filed under two different policy years, it must be filed under the earlier policy year.

ARTICLE V. LIMITATIONS OF COVERAGE

A. This Policy is between You and Us. No other party has any rights under this Policy.

B. Coverage for Plan Benefits Incurred for an employee who is not actively at work as a result of sickness, accidental bodily injury, maternity, military service, personal reasons, lay-off, strike, or any other leave of absence (either before or after the effective date of the Policy), or the employee's covered dependent(s), unless the employee or dependent(s) are receiving continuation benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, shall be limited to the length of time specified in the Plan Document.

C. All Plan Benefits Incurred outside the United States of America will be excluded from coverage unless:

1. The service(s) would have been a Covered Expense if the service(s) had been provided in the United States, and
2. The Covered Person is not covered by any other country's national health care program or any employer's foreign voluntary compensation coverage.

ARTICLE VI. EXCLUSIONS

WE will not reimburse YOU for:

A. Plan Benefits covered by amendments to the Employee Benefit Plan that were incurred prior to Our written approval of such amendments.

B. Plan Benefits that are covered under any Coordination of Benefits provision. We may elect to reduce or deny any reimbursement which may be payable to You, to the extent that a payment may be made by another insurer, another Employee Benefit Plan or any other party, to either the Employee Benefit Plan or Covered Person. This provision is applicable irrespective of how such payment is characterized and whether or not payment has actually been made for any or all of the Covered Person's losses.

C. Plan Benefits paid for any surgery, prescription drugs, device, or procedure, which is defined as Experimental or Investigative and any complications or other expenses arising thereto.

D. Plan Benefits Incurred by or on behalf of an employee or dependent of an employee of any affiliated or subsidiary company not included in the Application, unless added by Policy endorsement.

ARTICLE VII. GENERAL PROVISIONS

A. CHANGES AND TERMINATIONS OF THE POLICY

1. Your Policy may be changed at any time with Our written consent.

2. Only an officer of The Company has the authority to alter this Policy, or to waive any of Our rights or requirements, and then only by written endorsement.

3. We reserve the right to change any Specific or Aggregate Premium Rates and Monthly Aggregate Factors with written notice to You as to the extent and effective date of the change at any time during Your Policy Year if:

a. Your Employee Benefit Plan is changed, or
b. The number of Covered Units Eligible under Your Policy:
    i. Drops below 15, or
    ii. Increases or decreases by 15% from the number of Covered Units on the first day of the Contract Period, or
    iii. Increases or decreases by 10% in any Contract Month from the prior Contract Month.
c. If we have agreed to reduce the Monthly Aggregate Factors, the Minimum Annual Aggregate Deductible and / or the Monthly Specific Premium Rates in consideration of Your agreement to implement a Cost Containment Program, we may recalculate in accordance with Our normal practice, the Monthly Aggregate Factors, the Minimum Annual Aggregate Deductible and / or the Monthly Specific Premium Rates if you have not followed the procedures relating to the Cost Containment Program as defined in Our agreement.
d. Upon the enactment of any law, regulation or amendment thereto, by any state or jurisdiction, which affects our liability under this Policy, and in Our judgment, requires such a change.

4. You may terminate the Policy by giving Us not less than 31 days written notice.

5. We may terminate this Policy prior to the end of a Contract Period by giving you 31 days written notice if You fail to comply with any provision of the Policy.

6. We may terminate this Policy at the end of the Contract Period by giving You 31 days written notice of such termination.

7. All insurance provided hereunder to You will automatically terminate:

    a. At the beginning of any Contract Month for which any premium for either Specific or Aggregate Stop Loss Insurance has not been paid in full by the end of the grace period, or
    b. On the date You fail to Pay claims promptly or make funds available to Pay claims promptly as required by this Policy, or
    c. On the date Your agreement with Your Plan Supervisor is terminated, or
    d. On the date You change Your Plan Supervisor before obtaining Our written consent for a successor Plan Supervisor, or
    e. On the date Your Employee Benefit Plan terminates or ceases to accept newly Incurred claims, whichever is earlier, or on the date You obtain other coverage for Your Employee Benefit Plan participants, or
    f. On the date You terminate the Policy for any reason prior to the end of the Contract Period. In this event, We will not be liable for any Plan Benefits Paid after the termination date, or
    g. At the end of the Contract Period unless You accept in writing Our terms for renewal of the Stop Loss Insurance before the end of the Contract Period, or
    h. On the expiration date of this Policy.

B. AMENDMENTS TO THE PLAN: You must give Us at least 31 days written notice of any proposed amendments to Your Employee Benefit Plan. No amendment to Your Employee Benefit Plan will be binding on Us until We have approved the amendment in writing.

C. ARBITRATION: Any controversy or dispute, involving Us that arises out of or relates to this Policy, shall be settled by arbitration in accordance with the rules of the American Arbitration Association. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction. This provision shall survive the termination of this Policy.

D. ASSIGNMENT: You may not assign any of Your rights under this Policy without Our prior written consent.

E. CLERICAL ERROR: Our obligations under this Policy will not be expanded by any clerical error whether by You or Us in creating or maintaining records or calculating rates, factors, premiums, deductibles or claims pertaining to this Policy. A clerical error is a mistake in performing a clerical function, such as typing, but does not include intentional acts or the failure to comply with the provisions of the Employee Benefit Plan or Policy.

F. CONCEALMENT OR MISREPRESENTATION: This Policy is issued based upon Our understanding that You, Your Plan Supervisor and your agent or broker have provided to Us a Complete Claims History. The Policy will be void if We find that You, your Plan Supervisor and your agent or broker have concealed or misrepresented any material fact or circumstance concerning this coverage or the Employee Benefit Plan's Complete Claims History, whether intentional or not. Our liability will be limited to return of the premium paid by You after deducting the amount of the reimbursements made by Us to You prior to the date of termination. If the amount of reimbursements paid to You exceeds the premium paid to Us, You will pay Us the difference. If We find that You, Your Plan Supervisor, your agent or broker have not provided to Us a Complete Claims History, We may, at Our option, either rescind the policy or re-underwrite coverages under this Policy, using all claims data available to Us.

G. CONFORMITY WITH STATE AND FEDERAL LAW: Any provision of this Policy, which, on its effective date, is in conflict with the laws of the state of jurisdiction or which is mandated by Federal law, is hereby amended to conform to the minimum requirements of said laws.

H. COST CONTAINMENT PROGRAM: We have the right to participate, at Our option and expense, in any savings or Cost Containment Program that You have in place. If no such program exists, We have the right to retain the services of a third party to implement a Cost Containment Program.

I. DISCLAIMER: We act only as an insurer to You. We are not a fiduciary or a party in interest to the Employee Benefit Plan or any participant. We do not assume any duty to perform any of the functions of, or to provide any of the reports required by, You by the Employee Retirement Income Security Act of 1974, as amended or any other applicable state or federal law. We assume no responsibility or obligation for the administration of Your Employee Benefit Plan or Your acts. We reserve the right to determine amounts payable under this Policy without regards to such acts.

J. ENDORSEMENTS: Any endorsements attached or subsequently issued by us shall become a part of this Policy.

K. ENTIRE AGREEMENT: This Policy and any attached endorsements, Your attached Application and your Plan Document are the entire agreement between You and Us. We have relied upon the underwriting information (including Complete Claims History and the Plan Document) provided by You in issuing this Policy and You represent such information is complete and accurate. Should We later learn such information was incomplete or incorrect, We have the right to modify the Policy as of the effective date to reflect the complete or correct information or to terminate the Policy.

L. INDEMNIFICATION, DEFENSE AND HOLD HARMLESS: You agree to indemnify, defend and hold Us harmless from any liability, including but not limited to, interest, penalties, attorney fees, extra contractual, exemplary or punitive damages ("expenses") arising from or relating to:

1. Any negligence, error, omission, defalcation or intentional acts by your Plan Supervisor, or

2. Any dispute involving Covered Person(s), former Covered Person(s), or any person(s) claiming entitlement to benefits under the Employee Benefit Plan, or

3. Any taxes We are assessed with respect to funds paid to or by You under Your Employee Benefit Plan, except any taxes or amounts paid to Us as premiums for this Policy.

We will promptly notify You upon discovery of matters to which Your obligations under this provision apply. We have the right to participate in the defense at Our expense. Without limiting the foregoing, if You fail to defend timely, We have the right, but not the duty, to defend and to compromise or settle the claim or other matters on Your behalf, for Your account and at Your risk.

M. INSOLVENCY: In the event of Your insolvency or bankruptcy, subject to the terms, conditions and limitations of this policy, We may pay to Your receiver, trustee, liquidator or legal successor amounts otherwise payable under this Policy. We will make such payments only if You have Paid all required premiums and have complied with Your obligations under this Policy. Nothing in this section shall increase Our liability beyond that which would have existed had You not become insolvent or bankrupt.

N. LEGAL ACTION: No legal action can be brought to recover under this Policy:

1. Until 60 days after the date a reimbursement claim is submitted, or

2. Two years after the date a reimbursement claim is required to be furnished. You shall notify Us in writing within 10 days after receipt of any objection, notice of legal action or complaint regarding Your handling of a claim.

O. NOTICE: Notice under this Policy will be given to You through Your Plan Supervisor and will be deemed to have been received by You.

P. OFFSET: We may offset payments due to You under this Policy against claims overpayments, cost containment charges and premiums due and unpaid.

Q. PAYMENT OF PREMIUMS:

1. Each premium is payable to HCC Life Insurance Company, P.O. Box 402032, Atlanta, GA 30384-2032 or such other place as We designate in writing.

2. Specific Stop Loss Insurance premiums are due on the first day of each calendar month, regardless of the effective date of the Policy. If the effective date is other than the first day of a calendar month, the first month's premium will be pro-rated.

3. Aggregate Stop Loss Premium(s) are due monthly or are payable in advance for the Policy Year, as stated in Your Application.

4. A grace period of 31 days is allowed for the payment of each premium after the first premium. If the premium is not paid during the grace period, the Policy will terminate without further notice as of the premium due date.

5. If we terminate this Policy for non-payment of premium, application may be made for reinstatement.

   All outstanding premiums, including the current month's premium, must be remitted within 10 days of the end of the grace period.

   Payment of premiums shall not guarantee reinstatement of the Policy. We reserve the right to conduct a diligent review of the Complete Claims History and re-underwrite the Policy as We deem necessary as part of the terms for reinstatement.

   If the Policy is terminated more than one time during a Policy Year for non-payment, no requests for reinstatement will be granted.

6. In no event, will more than three (3) months of retroactive credit be granted for any clerical error(s) in the remittance of any premium.

R. POLICY NON-PARTICIPATING: This Policy is non-participating and does not entitle You to share in Our earnings.

S. RECORDS: You and / or Your Plan Supervisor will maintain such records as may be required by Us for this Policy and will make them available to us upon Our request. These records may include, but are not limited to, the Complete Claims History. We may audit Your records relating to this Policy and the claims filed under the Employee Benefit Plan at any time during the Policy Year and for two years after the expiration date of such Policy. Your records will include records held by You or by Your Plan Supervisor. As a result of any audit, We may readjust your Monthly Specific Premium Rates, Monthly Aggregate Factors, premiums, deductibles or expenses as may be necessary to reflect Our original intent in underwriting this Policy.

T. RENEWAL: Unless terminated for any of the reason(s) described in this Policy, Your insurance will be renewed for another Policy Year if You accept Our renewal terms. We will not change rates more than once in any Policy Year, except as allowed under the Changes and Termination Provisions in Article VII.

We reserve the right to change the renewal premium rates and Monthly Aggregate Factors for the new Contract Period if the average monthly payments made by You for Plan Benefits during the last two months of the current Policy Year vary by more than 30% from the average of the monthly payments made for Plan Benefits during the previous ten (10) Contract Months.

We will not offer a renewal if We are no longer doing business with Your Plan Supervisor.

U. SUBSIDIARIES AND AFFILIATED COMPANIES: You must notify Us in the event You acquire a subsidiary or affiliated company that will be included under Your Employee Benefit Plan. If You do acquire a subsidiary or affiliated company that will be included under Your Employee Benefit Plan, You must disclose certain claims information on the acquired subsidiary as a whole and / or on persons whose coverage You will be assuming under Your Employee Benefit Plan. Failure to do so will subject benefits under this Policy to certain limitations, as described under the ENTIRE AGREEMENT provision of this Article.

Acquisition of a subsidiary or affiliated company that will be included under Your Employee Benefit Plan may affect Your Monthly Specific Premium Rates and/or Monthly Aggregate Factors, as described in the CHANGES AND TERMINATIONS provision of this Article.

You must notify Us in the event You cede or dissolve a subsidiary or affiliated company that was included under your Employee Benefit Plan. Failure to do so may subject this Policy to termination or may affect Your Monthly Specific Premium Rates and/or Monthly Aggregate Factors as described in the CHANGES AND TERMINATIONS provision of this Article.

V. TAXES: You shall hold Us harmless from any taxes, which may be assessed against Us with respect to Your Employee Benefit Plan or with respect to claims for Covered Expenses paid under the Policy, and You shall reimburse Us for such taxes, if any, as determined by Us.

W. YOUR DESIGNATED PLAN SUPERVISOR (YOUR TPA). We agree to recognize Your Plan Supervisor as Your agent and attorney-in-fact for the administration of Your Employee Benefit Plan. You agree that:

1. Your Plan Supervisor is Your agent and attorney-in-fact, and is not Our agent. You authorize Your Plan Supervisor to act in Your name, place and stead for purposes of this Policy, to include submission of proofs of loss, certifying the Payment of Plan Benefits, transmitting reports and payments of premiums to Us and receiving reimbursements from Us. Payments sent by Us to Your Plan Supervisor are payments to You. Premium payments by You through Your Plan Supervisor will be payments to Us only to the extent We actually receive them.

2. You or Your Plan Supervisor is responsible for administering Your Employee Benefit Plan, preparing reports as required by Us and keeping and making available to Us such data as We may require.

3. You or Your Plan Supervisor will perform such duties and keep such records as are required for You to comply with this Policy.

4. You will pay Your Plan Supervisor for all administrative functions performed in relation to this Policy.

5. We reserve the right to cease doing business with Your Plan Supervisor.

STOP LOSS INSURANCE

HCC LIFE INSURANCE COMPANY

Three Town Park Commons, 225 TownPark Drive, Suite 145
Kennesaw, Georgia 30144 (800 447-0460)

APPLICATION

1. Full Legal Name of Applicant and Address

Telephone No.:

2. Applicant is a (check one)**:** ☐ Corporation ☐ Labor Union ☐ Partnership ☐ Association ☐ MEWA ☐ PEO ☐ Other:

3. Contract Period: Effective Date: Expiration Date:

4. Full Legal Name of Affiliates, Subsidiaries and other major locations to be included in coverage:

Address of Affiliates or Subsidiaries:
☐ None ☐ See attached listing

5. Nature of Business of the Applicant to be Insured:

6. Key Contact Person at Applicant:

7. Enter full name of the Employee Benefit Plan(s):

A signed copy of such Employee Benefit Plan(s) must be attached and will form part of this contract.

8. Name and Address of Plan Supervisor:

9. Agent of Record:

10. Estimated Initial Enrollment. Single: Family: Total Covered Units:

11. Retirees Covered: ☐ Yes ☐ No

12. The Utilization Review vendor will be:

13. Deposit Premium (Minimum of first month's estimated premium)**:** $
Please review the deposit premium on the Monthly Premium Accounting Worksheet.

14. SPECIFIC STOP LOSS INSURANCE: ☐ Yes ☐ No

A. Covered Expenses Paid under the Employee Benefit Plan for the following Plan Benefits are covered for Specific Stop Loss Insurance (not included unless checked):
☐ Medical ☐ Prescription Drug Card ☐ Prescription Drugs Under Medical ☐ Other:

B. Specific Deductible in each Contract Period per Covered Person or per Covered Family: $

C. Contract Basis:
Covered Expenses **Incurred** from [Date] through [Date] and **Paid** from [Date] through [Date]

D. [Unlimited Specific Lifetime Reimbursement Maximum per Covered Person or Covered Family]
[Specific Contract Period Reimbursement Maximum per Covered Person or Covered Family: $]

E. Separate Individual Specific Deductible:
[Name] for [Amount]

F. Monthly Specific Premium Rates: Single: $ Family: $

G. Specific Percentage Reimbursable _____%

H. Specific Terminal Liability Option: ☐ Yes ☐ No
Specific Terminal Liability Option premium per Covered Person per month: $

Applicant's Initials:_____

15. AGGREGATE STOP LOSS INSURANCE: ☐ Yes ☐ No

A. Covered Expenses Paid under the Employee Benefit Plan for the following Plan Benefits are covered for Aggregate Stop Loss Insurance (not included unless checked):
☐ Medical ☐ Dental ☐ Weekly Income ☐ Vision ☐ Prescription Drug Card
☐ Prescription Drugs Under Medical ☐ Other:

B. Minimum Annual Aggregate Deductible: $
(Subject to the Definition of Minimum Annual Aggregate Deductible in the Policy)

C. Contract Basis:
Covered Expenses **Incurred** from [Date] through [Date], and **Paid** from [Date] through [Date].
Run-In claims limited to: $

D. Aggregate Contract Period Reimbursement Maximum: $

E. Monthly Aggregate Factors:

Monthly Factors	Combined	Medical	Dental	Weekly Income	Vision	Prescription Drugs
Composite						
Single						
Family						

F. Aggregate Percentage Reimbursable _____%

G. Loss Limit: $
For the purposes of Aggregate Stop Loss Insurance, the Loss Limit is the maximum amount of Covered Expenses Incurred by each Covered Person (or Covered Family), which can be used to satisfy the Annual Aggregate Deductible.

H. Monthly Deductible Advance Reimbursement Option: ☐ Yes ☐ No

I. Aggregate Terminal Liability Option: ☐ Yes ☐ No

J. Aggregate Premium:
1. ☐ Annual Premium payable in advance for Contract Period: $
2. ☐ Monthly Premium rate per Covered Unit: $
3. ☐ Monthly Deductible Advance Reimbursement premium per Covered Unit per month: $
4. ☐ Aggregate Terminal Liability Option premium per Covered Unit per month: $

SPECIAL LIMITATIONS:
Specific:

_____

_____

Aggregate:

_____

_____

It is understood and agreed by the Applicant that:

1. The Applicant is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan, and
2. The Plan Supervisor retained by the Applicant will be considered the Applicant's Agent, and not the Company's Agent, and
3. All documentation requested by the Company must be received within 90 days of the Policy effective date, and is subject to approval by the Company and may require adjustment of rates, factors, and / or Special Limitations to accommodate for abnormal risks, and
4. The Stop Loss Insurance applied for herein will not become effective until accepted by the Company, and
5. Premiums are not considered paid until the premium check is received by the Company, is paid according to the rates set forth in the Application, and all items required to issue the Policy have been returned to the Company. Premiums are subject to refund should any outstanding policy requirement not be met within 90 days of the Policy's effective date, and
6. This Application will be attached to and made a part of the Policy issued by the Company, and
7. The Employee Benefit Plan(s) attached shall be the basis of any Stop Loss Insurance provided by the Company and such Employee Benefit Plan(s) conforms with all applicable State and Federal statutes, and
8. Any reimbursement under the Stop Loss Insurance provided by the Company shall be based on Covered Expenses Paid by the Applicant in accordance with the Employee Benefit Plan(s) attached hereto, and
9. After diligent and complete review, the representations made in this Application, the disclosures made, and all of the information provided for underwriters to evaluate the risk, are true and complete.

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover **claims reimbursable under a stop loss policy.**

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Full Legal Name of Applicant: Applicant's Federal Tax I.D. Number:

Dated at _____ this _____ day of _____, 20_____.

_____ _____

Officer / Partner Signature (print name) Licensed Agent Signature (print name)

For HCC Life Insurance Company Use Only: ACCEPTANCE
Accepted on behalf of the Company, this ____ day of _____, 20____.

By:_____ Title: _____

Policy No.: _____

SERFF Tracking Number:	*HCCH-126714556*	*State:*	*Arkansas*
Filing Company:	*HCC Life Insurance Company*	*State Tracking Number:*	*46167*
Company Tracking Number:	*PPACA HCCL MSL-2010*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Medical Stop Loss*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	07/21/2010

Comments:

HCC Life is filing a new application with this filing to replace the previously approved application on file with the State. Attached is the red line of the application attached on the form schedule tab. This application is state specific to include the notice from Bulletin 6-2008.

Attachment:

HCCL MSL-2010 APP AR - Redline.pdf

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	07/21/2010

Comments:

Attachment:

HCCL MSL-2010 Signed Readability Certification.pdf

		Item Status:	Status Date:
Satisfied - Item:	Filing Cover Letter	Approved-Closed	07/21/2010

Comments:

Attachment:

AR PPACA Filing Letter.pdf

		Item Status:	Status Date:
Satisfied - Item:	HCCL MSL-2010 Redline	Approved-Closed	07/21/2010

Comments:

Attachment:

HCCL MSL-2010 - redline.pdf

STOP LOSS INSURANCE
HCC LIFE INSURANCE COMPANY
Three Town Park Commons, 225 TownPark Drive, Suite 145
Kennesaw, Georgia 30144 (800 447-0460)
APPLICATION

1. Full Legal Name of Applicant and Address

Telephone No.:

2. Applicant is a (check one)**:** ☐ Corporation ☐ Labor Union ☐ Partnership ☐ Association ☐ MEWA ☐ PEO ☐ Other:

3. Contract Period: Effective Date: Expiration Date:

4. Full Legal Name of Affiliates, Subsidiaries and other major locations to be included in coverage:

Address of Affiliates or Subsidiaries:
☐ None ☐ See attached listing

5. Nature of Business of the Applicant to be Insured:

6. Key Contact Person at Applicant:

7. Enter full name of the Employee Benefit Plan(s):

A signed copy of such Employee Benefit Plan(s) must be attached and will form part of this contract.

8. Name and Address of Plan Supervisor:

9. Agent of Record:

10. Estimated Initial Enrollment. Single: Family: Total Covered Units:

11. Retirees Covered: ☐ Yes ☐ No

12. The Utilization Review vendor will be:

13. Deposit Premium (Minimum of first month's estimated premium)**:** $
Please review the deposit premium on the Monthly Premium Accounting Worksheet.

14. SPECIFIC STOP LOSS INSURANCE: ☐ Yes ☐ No

A. Covered Expenses Paid under the Employee Benefit Plan for the following Plan Benefits are covered for Specific Stop Loss Insurance (not included unless checked):
☐ Medical ☐ Prescription Drug Card ☐ Prescription Drugs Under Medical ☐ Other:

B. Specific Deductible in each Contract Period per Covered Person or per Covered Family: $

C. Contract Basis:
Covered Expenses **Incurred** from [Date] through [Date] and **Paid** from [Date] through [Date]

D. [Unlimited Specific Lifetime Reimbursement Maximum per Covered Person or Covered Family]
[Specific Contract Period Reimbursement Maximum per Covered Person or Covered Family: $]

E. Separate Individual Specific Deductible:
[Name] for [Amount]

F. Monthly Specific Premium Rates: Single: $ Family: $

G. Specific Percentage Reimbursable _____%

H. Specific Terminal Liability Option: ☐ Yes ☐ No
Specific Terminal Liability Option premium per Covered Person per month: $

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15. AGGREGATE STOP LOSS INSURANCE: ☐ Yes ☐ No

A. Covered Expenses Paid under the Employee Benefit Plan for the following Plan Benefits are covered for Aggregate Stop Loss Insurance (not included unless checked):
☐ Medical ☐ Dental ☐ Weekly Income ☐ Vision ☐ Prescription Drug Card
☐ Prescription Drugs Under Medical ☐ Other:

B. Minimum Annual Aggregate Deductible: $
(Subject to the Definition of Minimum Annual Aggregate Deductible in the Policy)

C. Contract Basis:
Covered Expenses **Incurred** from [Date] through [Date], and **Paid** from [Date] through [Date].
Run-In claims limited to: $

D. Aggregate Contract Period Reimbursement Maximum: $

E. Monthly Aggregate Factors:

Monthly Factors	Combined	Medical	Dental	Weekly Income	Vision	Prescription Drugs
Composite						
Single						
Family						

F. Aggregate Percentage Reimbursable _____%

G. Loss Limit: $
For the purposes of Aggregate Stop Loss Insurance, the Loss Limit is the maximum amount of Covered Expenses Incurred by each Covered Person (or Covered Family), which can be used to satisfy the Annual Aggregate Deductible.

H. Monthly Deductible Advance Reimbursement Option: ☐ Yes ☐ No

I. Aggregate Terminal Liability Option: ☐ Yes ☐ No

J. Aggregate Premium:
1. ☐ Annual Premium payable in advance for Contract Period: $
2. ☐ Monthly Premium rate per Covered Unit: $
3. ☐ Monthly Deductible Advance Reimbursement premium per Covered Unit per month: $
4. ☐ Aggregate Terminal Liability Option premium per Covered Unit per month: $

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SPECIAL LIMITATIONS:
Specific:

_____

_____

Aggregate:

_____

_____

It is understood and agreed by the Applicant that:

1. The Applicant is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan, and
2. The Plan Supervisor retained by the Applicant will be considered the Applicant's Agent, and not the Company's Agent, and
3. All documentation requested by the Company must be received within 90 days of the Policy effective date, and is subject to approval by the Company and may require adjustment of rates, factors, and / or Special Limitations to accommodate for abnormal risks, and
4. The Stop Loss Insurance applied for herein will not become effective until accepted by the Company, and
5. Premiums are not considered paid until the premium check is received by the Company, is paid according to the rates set forth in the Application, and all items required to issue the Policy have been returned to the Company. Premiums are subject to refund should any outstanding policy requirement not be met within 90 days of the Policy's effective date, and
6. This Application will be attached to and made a part of the Policy issued by the Company, and
7. The Employee Benefit Plan(s) attached shall be the basis of any Stop Loss Insurance provided by the Company and such Employee Benefit Plan(s) conforms with all applicable State and Federal statutes, and
8. Any reimbursement under the Stop Loss Insurance provided by the Company shall be based on Covered Expenses Paid by the Applicant in accordance with the Employee Benefit Plan(s) attached hereto, and
9. After diligent and complete review, the representations made in this Application, the disclosures made, and all of the information provided for underwriters to evaluate the risk, are true and complete.

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover **claims reimbursable under a stop loss policy.**

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Full Legal Name of Applicant: Applicant's Federal Tax I.D. Number:

Dated at _____ this _____ day of _____, 20_____.

_____ _____

Officer / Partner Signature (print name) Licensed Agent Signature (print name)

For HCC Life Insurance Company Use Only: ACCEPTANCE
Accepted on behalf of the Company, this ____ day of _____, 20____.

By:_____ Title: _____

Policy No.: _____

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HCC LIFE INSURANCE COMPANY

225 TownPark Drive, Suite 145, Kennesaw, Georgia 30144 Telephone: (770) 973-9851 Facsimile: (770) 973-9854

July 7, 2010

Certificate of Readability

I, Bradley T. Long, as an officer of HCC Life Insurance Company hereby certify that the form listed below has the following readability score as calculated by the Flesch Reading Ease Test.

Form Number	Form Name	Score
HCCL MSL-2010	Medical Stop Loss Policy	49.1

Respectfully,

Bradley T. Long
Assistant Vice President, Compliance
800/447-0460 Ext. 485
blong@hcclife.com

HCC LIFE INSURANCE COMPANY

225 TownPark Drive, Suite 145, Kennesaw, Georgia 30144 Telephone: (770) 973-9851 Facsimile: (770) 973-9854

July 9, 2010

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

RE: HCC Life Insurance Company
NAIC #: 92711 – FEIN #: 35-1817054
Group Medical Stop Loss
Form Numbers: HCCL MSL-2010 et al.

HCC Life Insurance Company ("HCC Life") writes medical stop loss insurance to employer groups that self-fund their employee health benefit plans. With the passage of the Patient Protection and Affordable Care Act ("PPACA"), each of our self-funded clients have had to make changes to their plan of benefits and HCC Life is having to alter our stop loss forms to accommodate these changes. These two new medical stop loss policy forms are intended to replace two HCC Life's stop loss forms previously approved in your state. Although stop loss forms were not addressed by the NAIC's Speed to Market Task Force in their recent efforts to accommodate health form changes due to PPACA, we would very much appreciate the Department's expedited handling of our form updates. Our self-funded policyholders are required to change their plans to comply with PPACA. Their stop loss coverage needs to be changed as well, so the Department's cooperation in handing this filing as quickly as possible will be helpful. HCC Life will immediately begin using these forms upon approval.

The table below indicates the new forms being filed and the forms they replace. Only the forms indicated on this table will be replaced. All other forms previously approved on the below referenced date, will continue to be used. For informational purposes only, included is also a copy of any applicable state-specific forms that are used to bring the stop loss forms into compliance with state requirements.

New Form Number	Old Form Number	Previous Filing Number	Date Approved	Description
HCCL MSL-2010	HCCL MSL-2007	34701	12/29/2006	Policy Form
HCCL MSL-2010 APP	HCCL MSL-2007 APP	34701	12/29/2006	Application

The only differences between the old policy form and the new policy form are: 1) edits to the specific and aggregate lifetime maximum wording, 2) language related to taxes incurred by the self-funded policyholder, and 3) protections added to protect HCC Life against the use of discretionary clauses in our policyholders' self-funded plans. Redline copies showing our changes are included with this filing.

Type of Submission: This filing is a stop loss / excess risk filing. HCC Life's stop loss contract provides excess risk coverage to employers with self-funded health plans. The majority of these plans are subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Variable Material: There are no variables other than those shown on the policy face page. Therefore, we have not included a description of variable material. It must be noted that no change in the variable areas will be made which will be in conflict with the law, rules and regulations of your state. In addition, no change in variability will be made which in any way expands the scope of the wording being changed.

State Stop Loss Restrictions: HCC Life certifies that its stop loss policy forms are compliant with all applicable state minimum specific deductible, minimum aggregate corridor and small group restrictions (if any). In states where limitations exist, edits are built into our underwriting system to prevent us from quoting or issuing a stop loss policy that is out of compliance with applicable state laws and regulations.

Domiciliary State: HCC Life's state of domicile is Indiana. This filing was submitted to Indiana on July 7, 2010 and is pending approval.

Thank you in advance for reviewing these new forms. If you have any questions or comments regarding this resubmission, please feel free to contact me. I will be glad to assist you in any way I can.

Respectfully,

Misty Pagelsen
Compliance Specialist II
800/447-0460 Ext. 455
770/693-6455 – direct
770/973-9854 – fax
mpagelsen@hcclife.com

HCC LIFE INSURANCE COMPANY
225 Town Park Drive, Suite 145
Kennesaw, Georgia 30144
1-800 447-0460

STOP LOSS POLICY

THIS IS A LEGAL CONTRACT - PLEASE READ IT CAREFULLY

Policy Number:

Policyholder:

Principal Address:

Designated Plan Supervisor (or TPA):

This Policy is issued in consideration of Your Application, Your Plan Document, Your Disclosure Statement and the payment of premiums. The aforementioned documents combine to form this Policy.

The effective date of this Policy is 12:01 a.m., at Your address and the expiration date of this Policy is 11:59 p.m., as shown below at Your principal address.

Effective Date:

Expiration Date:

This Policy is issued by Us as of the Effective Date, but is not valid unless countersigned by Our duly authorized representative.

Jurisdiction of Issue: [Any State]

This policy is governed by the laws of the jurisdiction of issue.

_____ _____

President Vice President and General Counsel

NON-PARTICIPATING INSURANCE

This is a reimbursement policy. You, or Your Plan Supervisor, are responsible for making benefit determinations under Your Employee Benefit Plan. We have no duty or authority to administer, settle, adjust, or provide advice regarding claims filed under Your Employee Benefit Plan.

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ARTICLE I. DEFINITIONS

When used in this Policy, the following terms will have the meanings as indicated below:

ANNUAL AGGREGATE DEDUCTIBLE. For any one Contract Period, (or any fraction thereof, if the Contract terminates during the Contract Period) the total of the number of Covered Single or Family units multiplied by its corresponding Monthly Aggregate Factor, applied each month that the Contract is in-force. In no instance shall the Annual Aggregate Deductible be less than the Minimum Annual Aggregate Deductible.

AGGREGATE CONTRACT PERIOD REIMBURSEMENT MAXIMUM. The maximum amount We will reimburse the Policyholder for Covered Expenses during each Contract Period under the terms of the Aggregate Stop Loss Insurance as shown on the Application.

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AGGREGATE PERCENTAGE REIMBURSABLE. The percentage of Covered Expenses to be reimbursed that were Paid under the Employee Benefit Plan in excess of the Annual Aggregate Deductible.

COBRA BENEFICIARY. Any former Covered Person of the Employee Benefit Plan continuing participation under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments.

COMPANY. Company, We, Our, and Us refers to HCC Life Insurance Company.

COMPLETE CLAIMS HISTORY. All of the following for a minimum of 12 consecutive months immediately preceding the Policy Year:

1. Participant census, and
2. Eligibility information, and
3. Claims Experience, and
4. Large Claim Disclosures, and
5. Details of any condition shown on the Trigger Diagnosis List in the Disclosure Statement.

CONTRACT. All of the following:

1. The Application, and
2. This Policy and any endorsements to it, and
3. The Policyholder's Plan Document.

CONTRACT BASIS. The form of coverage shown on the Application that was selected by the Policyholder. The Contract Basis shall be considered in determining what Covered Expenses will be reimbursed by Us.

CONTRACT MONTH. A period of one-month that begins on:

1. The effective date of the Policy, or
2. The same day of each following month during the Contract Period.

CONTRACT PERIOD. The period of time shown on the Application during which the Policyholder is covered for Aggregate and / or Specific Stop Loss Insurance.

COST CONTAINMENT PROGRAM. A program designed to reduce or control the cost of providing Plan Benefits to participants of the Employee Benefit Plan.

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COVERED EXPENSES. Plan Benefits incurred by a Covered Person (or Covered Family):

1. For which benefits are Paid by the Policyholder under the Employee Benefit Plan, and
2. Which are not in excess of the Reasonable and Customary Charge for those services, and
3. Which are Medically Necessary for the treatment of an illness or injury or for any preventative care covered by the Employee Benefit Plan, and
4. Which are reimbursable under this policy subject to its terms, deductible(s), limitations and exclusions.

Plan Benefits provided by the Employee Benefit Plan that are specifically excluded by this Policy are not considered Covered Expenses. Covered Expenses shall not include any expenses which are not reimbursable under this Policy, such as:

1. The expenses related to processing claim payment, or
2. PPO discounts, network or negotiated discounts, and other reductions from billed charges, whether or not they were actually deducted from Plan Benefits, or
3. Salaries paid to any individual, or
4. Plan Supervisor's fees, or
5. Litigation expenses, or
6. Premiums paid for coverage under this Policy.

COVERED FAMILY. The Covered Person and his or her dependents covered under the Employee Benefit Plan.

COVERED PERSON. If so indicated on the Application, an individual covered under the Employee Benefit Plan. This includes:

1. Legally employed covered employees, and
2. Covered dependents, and
3. Participating COBRA Beneficiaries, and
4. Retirees.

COVERED UNITS. A Covered Person, a Covered Family, or such other defined unit as agreed upon between You and Us in writing.

DEDUCTIBLE. The amount of Covered Expenses You must pay before Aggregate Stop Loss Insurance and / or Specific Stop Loss Insurance benefits become reimbursable. The Deductible(s) is / are shown on the Application issued to You. See also:

1. Annual Aggregate Deductible, and
2. Specific Deductible, and
3. Specific Family Deductible.

ELIGIBLE. Eligible under the Employee Benefit Plan.

EMPLOYEE BENEFIT PLAN. The medical benefits You have agreed to provide under a plan of benefits for Your Eligible employees and their Eligible dependents, whether or not it is subject to the Employee Retirement Income Security Act of 1974, as is or as may be amended.

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EXPERIMENTAL AND INVESTIGATIVE. A drug, device or medical treatment or procedure is Experimental or Investigative:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, or
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II or III clinical trials or under study to determine its:
   a. Maximum tolerated dose, or
   b. Toxicity, or
   c. Safety, or
   d. Efficacy, or
   e. Efficacy as compared with the standard means of treatment or diagnosis, or
3. If reliable evidence shows that the consensus among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
   a. Maximum tolerated dose, or
   b. Toxicity, or
   c. Safety, or
   d. Efficacy, or
   e. Efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative peer reviewed medical and scientific literature, or
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure, or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

INCURRED. The date on which medical care or a service or supply is provided to a Covered Person for Plan Benefits under the Employee Benefit Plan for which a charge results.

LARGE CLAIM DISCLOSURE. You, with the assistance of Your Plan Supervisor, agree to disclose to us any known or potential shock losses. Shock Losses are:

1. Injuries, and
2. Illnesses, and
3. Diseases, and
4. Diagnoses, and
5. Any condition listed on the Trigger Diagnosis list, and
6. Other losses of the type, which are reasonably expected or are likely to result in significant medical expense or liability.

LOSS LIMIT. The maximum amount of Covered Expenses Incurred by each Covered Person (or Covered Family), which can be used to satisfy the Annual Aggregate Deductible. This amount is shown in the Application. The maximum allowable amount of Covered Expenses by a Covered Person who has been assigned a Separate Individual Specific Deductible will be the specified amount as shown under the Loss Limit on the Application, regardless of that Covered Person's Separate Individual Specific Deductible.

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MEDICALLY NECESSARY. A procedure, treatment, service, supply, equipment, drug or medicine that is:

1. Deemed appropriate, essential and is recommended for the diagnosis or treatment of the Covered Person's symptoms by a licensed physician, dentist or other medical practitioner who is practicing within the scope of his or her license and specialty or primary area of practice, and
2. Within the scope, duration and intensity of that level of care which is required to provide safe, adequate and appropriate diagnosis or treatment, and
3. Prescribed in accordance with the generally accepted, current professional medical practice and is not considered Experimental or Investigative.

MINIMUM ANNUAL AGGREGATE DEDUCTIBLE. For each Contract Period, the number of Contract Months times the Monthly Aggregate Factor times the number of Covered Units. Covered Units shall be based on the first month's enrollment or the quoted enrollment whichever is greater. The Minimum Annual Aggregate Deductible as shown on the Application is based on the quoted enrollment and it is subject to change if the first month's enrollment is greater.

MONTHLY AGGREGATE DEDUCTIBLE. The Monthly Aggregate Deductible is determined for each Contract Month by multiplying the number of Covered Units for that month by the applicable Monthly Aggregate Factor(s) shown on the Application.

MONTHLY AGGREGATE FACTOR. The amount specified in the Application.

MONTHLY SPECIFIC PREMIUM RATES. The amounts specified in the Application.

NET PAID CLAIMS. The sum of Covered Expenses Paid during the Policy Year by You less the sum of all amounts paid by You that exceeds the Loss Limit of any Covered Person(s).

ORIGINAL EFFECTIVE DATE. The first day of the Contract Period of Your initial Stop Loss Policy with Us subject to any Run-In Period as shown on the Application. If coverage has not been continuous with Us, then the Original Effective Date shall be the first day of the most recent continuous coverage.

PAY, PAID, PAYMENT. Charges that, as of the dates shown in the Contract Basis, are:

1. Covered and payable under your Employee Benefit Plan, and
2. Have been adjudicated and approved, and
3. A check or draft for remuneration is issued and deposited in the U.S. Mail, or other similar conveyance or is otherwise delivered to the payee, and
4. Sufficient funds are on deposit the date the check or draft is issued.

Our reimbursements will not be made until all of these conditions are satisfied. Checks or drafts that are returned to the payor unpaid for any reason will not be considered Paid.

PLAN BENEFITS. The medical expense benefits to which Covered Persons become entitled under the Employee Benefit Plan during the Policy Year which are:

1. Incurred after the effective date of this Policy or the first date of the Run-In Period, and
2. Incurred while this Policy is in-force, and
3. Paid during the Policy Year or before the end of the Run-Out Period.

Plan Benefits do not include:

1. Deductibles, or
2. Co-insurance amounts, or

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3. Interest, or
4. Expenses, or
5. The amounts of any PPO discounts, network or negotiated discounts, or any other reductions to billed charges, whether or not they were actually deducted, and
6. Claims paid under an Employee Benefit Plan's discretionary clause or similar provision that would not otherwise be payable under the terms and conditions of the Employee Benefit Plan, and
7. Claims that are not covered under the terms and conditions of the Employee Benefit Plan or that are reimbursable from any other source.

An Employee Benefit Plan expense is incurred at the time the serviced is rendered or the supply is provided.

PLAN DOCUMENT. The written document evidencing Your Employee Benefit Plan including any amendments. You will provide Us with a copy of Your Plan Document that is in effect as of the Policy effective date. Amendments are subject to Article VI, Item D and Article VII, Item A.3.a of this Policy. We will provide written confirmation of receipt of this Plan Document. The Plan Document does not waive of any provisions of this Policy.

PLAN SUPERVISOR (TPA). The person or entity selected by the Plan Sponsor and approved by Us to perform administrative services for the Employee Benefit Plan, including payment of claims.

POLICY YEAR. The period beginning on the effective date and ending on the expiration date as shown on the face page of this Policy, or the actual period of time during which the Policy is in force if the Policy terminates prior to the expiration date.

POLICYHOLDER. Employer, Insured, You, Your or Plan Sponsor.

REASONABLE AND CUSTOMARY CHARGE. Charges for medical expenses, including but not limited to, physician services, hospital supplies, hospital bed rates, drugs, ancillary services and durable medical equipment usually made by such providers in the same geographical area using nationally and regionally adjusted data.

RUN-IN PERIOD. The period of time as defined under the Contract Basis on the Application during which claims for Plan Benefits may be Incurred provided they are Paid during the Contract Period.

RUN-OUT PERIOD. The period of time as defined under the Contract Basis on the Application during which claims for Plan Benefits may be Paid provided they were Incurred during the Contract Period.

SPECIFIC CONTRACT PERIOD REIMBURSEMENT MAXIMUM. The maximum amount of Covered Expenses We will reimburse You in each Contract Period for any one Covered Person (or Covered Family). This amount shall not exceed the amount shown as the Specific Contract Period Reimbursement Maximum on Your Application, or any maximum benefit amount or limit defined in Your Employee Benefit Plan, whichever is less.

SPECIFIC DEDUCTIBLE. If a Specific Deductible is shown on the Application, this is the amount of Covered Expenses that must be Paid by the Employee Benefit Plan for any Covered Person before Specific Stop Loss Insurance benefits are reimbursable under the Policy. It applies separately for each Policy Year and will be determined annually by Us.

SPECIFIC FAMILY DEDUCTIBLE. If a Specific Deductible is shown on the Application per a Covered Family, this is the amount of Covered Expenses which must be Paid by the Employee Benefit Plan for any Covered Family member or combination of Covered Family members before Specific Stop Loss Insurance benefits are reimbursable under the Policy. It applies separately for each Policy Year and will be determined annually by Us.

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SPECIFIC PERCENTAGE REIMBURSABLE. The percentage of Covered Expenses to be reimbursed that were Paid under the Employee Benefit Plan in excess of the Specific Deductible.

ARTICLE II. SPECIFIC STOP LOSS INSURANCE

A. Subject to the terms, conditions and limitations of this Policy, We will reimburse You for Covered Expenses Paid in excess of the Specific Deductible (or Specific Family Deductible).

B. We will not reimburse you for any amounts after the Specific Contract Period Reimbursement Maximum has been reached.

C. We will not reimburse You for Plan Benefits Incurred after the Policy's expiration date.

D. If the Policy terminates before the expiration date, Plan Benefits paid after the date of termination will not be eligible for reimbursement.

E. Plan Benefits Paid by You which have been reimbursed by Us under Your Aggregate Stop Loss Insurance or by another insurance company or reinsurance company will not be used to:

1. Satisfy the Specific Deductible (or the Specific Family Deductible), or
2. Compute Specific Stop Loss Insurance benefits payable to You.

F. The Monthly Specific Premium Rates shown on the Application apply only to the Policy Year shown therein. New Monthly Specific Premium Rates will be furnished for each new Policy Year and will be shown on a new Application provided for each Policy Year.

ARTICLE III. AGGREGATE STOP LOSS INSURANCE

A. Subject to the terms, conditions and limitations of this Policy, We will reimburse You for Eligible Covered Expenses Paid, less:

1. The Annual Aggregate Deductible or the Minimum Annual Aggregate Deductible, whichever is greater, and
2. Specific Stop Loss reimbursements due or paid to You, and
3. Any amounts paid by you that exceeds the Loss Limit for any Covered Person (or Covered Family).

B. We will not reimburse you for any amounts after the Aggregate Contract Period Reimbursement Maximum has been reached.

C. We will not reimburse You for Plan Benefits Incurred after the Policy's expiration date.

D. If the Policy terminates before the expiration date, any Plan Benefits paid after the date of termination will not be eligible for reimbursement.

E. Plan Benefits Paid by You which have been reimbursed by Us under Your Specific Stop Loss Insurance, by another insurance company or reinsurance company will not be used to:

1. Satisfy the Annual Aggregate Deductible or the Minimum Annual Aggregate Deductible, or
2. Compute the Aggregate Stop Loss Insurance benefits payable to You.

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F. Plan Benefits Paid by You which exceed the Specific Contract Period Reimbursement Maximum for Specific Stop Loss Insurance as shown on the Application will not be used to:

1. Satisfy the Annual Aggregate Deductible or Minimum Annual Aggregate Deductible, or
2. Compute the Aggregate Stop Loss Insurance benefits payable to You.

G. Reimbursement for Aggregate Stop Loss Insurance for any Covered Person (or Covered Family) will be limited to an amount not to exceed the Specific Deductible (or Specific Family Deductible) or the Loss Limit, whichever is less, as set forth in the Application.

H. The Monthly Aggregate Factor(s) shown on the Application apply only to the Policy Year shown therein. New Monthly Aggregate Factors will be furnished for each new Policy Year and will be shown on a new Application provided for each Policy Year.

I. The Monthly Aggregate Deductible cannot be reduced by more than 10% per month if the number of Covered Persons decreases for any reason. If any Covered Persons are absent from work due to a strike, lockout, or work stoppage during any Contract Month, the number of Covered Persons will remain at the same level as for the Contract Month preceding the disruption.

ARTICLE IV. CLAIMS UNDER THE POLICY

A. Specific Claims

1. We will reimburse You for Specific Stop Loss Insurance, subject to the terms, conditions and limitations of this Policy, only after We receive a request for reimbursement with complete claim information.

2. The following documentation is required to file a Specific Stop Loss claim:

   a. *Specific Claim Notification / Initial Filing form*, and
   b. A copy of the employee's enrollment card, including the employee's hire date and the original effective date, and
   c. A copy of the Plan Supervisor's claim form if the claim is for a dependent, and
   d. Complete details regarding eligibility, and if applicable, information regarding work status, pre-existing / HIPAA documentation, subrogation, Coordination of Benefits, provider discounts and COBRA, including a copy of the COBRA election form and COBRA payment verification for all months, and
   e. Copies of *Explanations of Benefits* attached to the corresponding itemized bills, and
   f. Check copies, if not part of an *Explanation of Benefits*, and
   g. Completion of the *Specific Supplemental Claim Request* portion of the claim form if applicable, and
   h. Miscellaneous information as applicable, including but not limited to:
      i. Complete accident details, including how, when and where an accident may have occurred, and
      ii. Police reports for motor vehicle accidents or for services for which a law enforcement agency is involved, and
      iii. A *Subrogation and Right of Recovery Reimbursement Agreement* if charges were Incurred as a result of a third party liability, and
      iv. Coordination of benefits documentation, and
      v. PPO discount / repricing sheets, and
      vi. *Large Case Management Reports*, and
   i. Other documentation We may request.

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3. [LATE CLAIMS: Any claim that is either submitted, or that remains incomplete, more than 90 days after the last date for which Plan Benefits can be reimbursed under the terms of the Policy will be denied, whether or not the delay has prejudiced Us. Your or Your Plan Supervisor's failure to file a complete claim in a timely manner may result in an adjustment of Our reimbursement to You to reflect any savings We could have obtained had a timely claim filing taken place pursuant to this provision.]

OR

[LATE CLAIMS: Satisfactory proof of loss must be provided to the Company within a reasonable amount of time after the 50% Notification or Large Claim Disclosure is received.]

Comment [b1]: For Incurred Contracts Basis only

4. [50% NOTIFICATION: You or Your Plan Supervisor must give notice to Us when the total amount of Plan Benefits Paid by You on a Covered Person equals or exceeds 50% of the Specific Deductible, or has the potential to exceed 50% of the Specific Deductible. Your failure to give prompt notice may result in an adjustment of Our reimbursement to You, if any, to reflect any savings We could have obtained had a prompt 50% Notification been given.]

OR

[50% NOTIFICATION: You or Your Plan Supervisor must give notice to Us when the total amount of Plan Benefits Paid by You on a Covered Person equals or exceeds 50% of the Specific Deductible, or has the potential to exceed 50% of the Specific Deductible. There is no specific coverage of a claim if written notice of the pending claim is not received by HCC Life within 12 months after the end of the Policy Year.]

Comment [b2]: For Incurred Contract Basis only

B. Aggregate Claims

1. We will reimburse You for Aggregate Stop Loss Insurance, subject to the terms, conditions and limitations of this Policy, only after We receive a request for reimbursement with Complete Claim History.

2. The following documentation is required to file an Aggregate Stop Loss claim:

   a. Completed *Year End Aggregate Claim Form*, and
   b. *Paid Claims Analysis report* indicating claimant's name, Incurred date, charged amount, Paid amount and Paid date, and
   c. Eligibility listing which identifies birth date, effective date, termination date and coverage type, and
   d. Proof of funding to include bank statements and/or deposit slips, and
   e. *Void & Refund report*, and
   f. *Benefit / Service Code report*, and
   g. *Aggregate Report* (Monthly Loss Summary Reports), and
   h. *Specific Report* showing which claimants have exceeded the Specific Deductible or Loss Limit, and
   i. Listing of payments made outside the Aggregate Stop Loss Insurance (i.e. Dental, Weekly Income, Vision, PPO fees capitated and, PCS Administrative Fees), and
   j. Check Register, and
   k. Outstanding overpayment and subrogation log, and
   l. Prescription invoices if Prescriptions are covered under the Aggregate Stop Loss Insurance, and
   m. Other documentation We may request.

   We may also request this information the month following the expiration date of the Policy to review for retroactive adjustments.

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3. Any reimbursement payable by Us to You, under this article, will be paid after the end of the Contract Period, unless otherwise endorsed.

4. CLAIM FILING: You must file a request for reimbursement with Us on Our customary Notice / Proof of Loss form within 90 days after the end of the time specified for payment of claims under this Policy. Your failure to file a claim within 90 days will result in claim denial, whether or not the delay has prejudiced Us.

5. DETERMINATION OF THE ULTIMATE AGGREGATE CLAIM: You must submit a Proof of Loss within 90 days of the end of the Policy Year or Run-Out Period, whichever is later, showing the amount of all Plan Benefits Eligible under the Employee Benefit Plan and this Policy which You have Paid. These shall be compared to the greater of the Annual Aggregate Deductible or the Minimum Annual Aggregate Deductible. If the amount of Net Paid Claims eligible under this policy is greater than the appropriate Annual Aggregate Deductible, We will reimburse You for the amount of the excess.

C. All Claims

1. REIMBURSEMENT OF CLAIMS: Prior to making any reimbursement, We have the right to review each claim submitted to Us to determine if You are entitled to any reimbursement under this Policy. This review may include, but is not limited to, an on-site audit or requests for additional documentation. You warrant that You have Paid the providers of Plan Benefits for which reimbursement is sought.

2. SETTLEMENT OF PLAN CLAIMS: We have no duty or obligation to settle or adjust any claims for Plan Benefits filed under Your Employee Benefit Plan.

3. RIGHT OF RECOVERY. If You are entitled to recover from any party Plan Benefits Paid under the Employee Benefit Plan, such amounts cannot be used to satisfy either the Specific and / or Aggregate Deductibles. We also will not reimburse You for any Plan Benefit recovered from any party. If We have reimbursed You for all or part of a Plan Benefit and You recover any part of the Plan Benefit from any party, You must repay Us to the extent of Our reimbursement regardless of whether the policy is still in-force on the date of the recovery. You must reimburse Us first, and in full, before You receive any benefit of the recovery. We retain the right to employ our own independent counsel and You assign to us Your rights and the Employee Benefit Plan's rights to the extent of Our reimbursement(s) to You.

   In the event that You reimburse Us in the matter where Our designated counsel is not involved, Your repayment may be reduced by the reasonable and necessary expenses incurred in recovering from the third party.

   If You fail to reimburse Us for a valid claim for a Covered Expense against a third party, and We are required to reimburse You for such a Covered Expense, We shall be subrogated to Your rights to pursue the claim.

   Any amount We recover shall first be used to pay Our expenses of collection and then apply towards any amount that We reimbursed You under the policy. Any remaining amount will be paid to You.

   You are required to provide Us with such information as We request in order to protect Our right to reimbursement.

4. CLAIMS ELIGIBLE UNDER TWO CONTRACTS. If a claim for reimbursement can be filed under two different policy years, it must be filed under the earlier policy year.

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ARTICLE V. LIMITATIONS OF COVERAGE

A. This Policy is between You and Us. No other party has any rights under this Policy.

B. Coverage for Plan Benefits Incurred for an employee who is not actively at work as a result of sickness, accidental bodily injury, maternity, military service, personal reasons, lay-off, strike, or any other leave of absence (either before or after the effective date of the Policy), or the employee's covered dependent(s), unless the employee or dependent(s) are receiving continuation benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, shall be limited to the length of time specified in the Plan Document.

C. All Plan Benefits Incurred outside the United States of America will be excluded from coverage unless:

1. The service(s) would have been a Covered Expense if the service(s) had been provided in the United States, and
2. The Covered Person is not covered by any other country's national health care program or any employer's foreign voluntary compensation coverage.

ARTICLE VI. EXCLUSIONS

WE will not reimburse YOU for:

A. Plan Benefits covered by amendments to the Employee Benefit Plan that were incurred prior to Our written approval of such amendments.

B. Plan Benefits that are covered under any Coordination of Benefits provision. We may elect to reduce or deny any reimbursement which may be payable to You, to the extent that a payment may be made by another insurer, another Employee Benefit Plan or any other party, to either the Employee Benefit Plan or Covered Person. This provision is applicable irrespective of how such payment is characterized and whether or not payment has actually been made for any or all of the Covered Person's losses.

C. Plan Benefits paid for any surgery, prescription drugs, device, or procedure, which is defined as Experimental or Investigative and any complications or other expenses arising thereto.

D. Plan Benefits Incurred by or on behalf of an employee or dependent of an employee of any affiliated or subsidiary company not included in the Application, unless added by Policy endorsement.

ARTICLE VII. GENERAL PROVISIONS

A. CHANGES AND TERMINATIONS OF THE POLICY

1. Your Policy may be changed at any time with Our written consent.

2. Only an officer of The Company has the authority to alter this Policy, or to waive any of Our rights or requirements, and then only by written endorsement.

3. We reserve the right to change any Specific or Aggregate Premium Rates and Monthly Aggregate Factors with written notice to You as to the extent and effective date of the change at any time during Your Policy Year if:

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a. Your Employee Benefit Plan is changed, or
b. The number of Covered Units Eligible under Your Policy:
   i. Drops below 15, or
   ii. Increases or decreases by 15% from the number of Covered Units on the first day of the Contract Period, or
   iii. Increases or decreases by 10% in any Contract Month from the prior Contract Month.
c. If we have agreed to reduce the Monthly Aggregate Factors, the Minimum Annual Aggregate Deductible and / or the Monthly Specific Premium Rates in consideration of Your agreement to implement a Cost Containment Program, we may recalculate in accordance with Our normal practice, the Monthly Aggregate Factors, the Minimum Annual Aggregate Deductible and / or the Monthly Specific Premium Rates if you have not followed the procedures relating to the Cost Containment Program as defined in Our agreement.
d. Upon the enactment of any law, regulation or amendment thereto, by any state or jurisdiction, which affects our liability under this Policy, and in Our judgment, requires such a change.

4. You may terminate the Policy by giving Us not less than 31 days written notice.

5. We may terminate this Policy prior to the end of a Contract Period by giving you 31 days written notice if You fail to comply with any provision of the Policy.

6. We may terminate this Policy at the end of the Contract Period by giving You 31 days written notice of such termination.

7. All insurance provided hereunder to You will automatically terminate:

   a. At the beginning of any Contract Month for which any premium for either Specific or Aggregate Stop Loss Insurance has not been paid in full by the end of the grace period, or
   b. On the date You fail to Pay claims promptly or make funds available to Pay claims promptly as required by this Policy, or
   c. On the date Your agreement with Your Plan Supervisor is terminated, or
   d. On the date You change Your Plan Supervisor before obtaining Our written consent for a successor Plan Supervisor, or
   e. On the date Your Employee Benefit Plan terminates or ceases to accept newly Incurred claims, whichever is earlier, or on the date You obtain other coverage for Your Employee Benefit Plan participants, or
   f. On the date You terminate the Policy for any reason prior to the end of the Contract Period. In this event, We will not be liable for any Plan Benefits Paid after the termination date, or
   g. At the end of the Contract Period unless You accept in writing Our terms for renewal of the Stop Loss Insurance before the end of the Contract Period, or
   h. On the expiration date of this Policy.

B. AMENDMENTS TO THE PLAN: You must give Us at least 31 days written notice of any proposed amendments to Your Employee Benefit Plan. No amendment to Your Employee Benefit Plan will be binding on Us until We have approved the amendment in writing.

C. ARBITRATION: Any controversy or dispute, involving Us that arises out of or relates to this Policy, shall be settled by arbitration in accordance with the rules of the American Arbitration Association. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction. This provision shall survive the termination of this Policy.

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D. ASSIGNMENT: You may not assign any of Your rights under this Policy without Our prior written consent.

E. CLERICAL ERROR: Our obligations under this Policy will not be expanded by any clerical error whether by You or Us in creating or maintaining records or calculating rates, factors, premiums, deductibles or claims pertaining to this Policy. A clerical error is a mistake in performing a clerical function, such as typing, but does not include intentional acts or the failure to comply with the provisions of the Employee Benefit Plan or Policy.

F. CONCEALMENT OR MISREPRESENTATION: This Policy is issued based upon Our understanding that You, Your Plan Supervisor and your agent or broker have provided to Us a Complete Claims History. The Policy will be void if We find that You, your Plan Supervisor and your agent or broker have concealed or misrepresented any material fact or circumstance concerning this coverage or the Employee Benefit Plan's Complete Claims History, whether intentional or not. Our liability will be limited to return of the premium paid by You after deducting the amount of the reimbursements made by Us to You prior to the date of termination. If the amount of reimbursements paid to You exceeds the premium paid to Us, You will pay Us the difference. If We find that You, Your Plan Supervisor, your agent or broker have not provided to Us a Complete Claims History, We may, at Our option, either rescind the policy or re-underwrite coverages under this Policy, using all claims data available to Us.

G. CONFORMITY WITH STATE AND FEDERAL LAW: Any provision of this Policy, which, on its effective date, is in conflict with the laws of the state of jurisdiction or which is mandated by Federal law, is hereby amended to conform to the minimum requirements of said laws.

H. COST CONTAINMENT PROGRAM: We have the right to participate, at Our option and expense, in any savings or Cost Containment Program that You have in place. If no such program exists, We have the right to retain the services of a third party to implement a Cost Containment Program.

I. DISCLAIMER: We act only as an insurer to You. We are not a fiduciary or a party in interest to the Employee Benefit Plan or any participant. We do not assume any duty to perform any of the functions of, or to provide any of the reports required by, You by the Employee Retirement Income Security Act of 1974, as amended or any other applicable state or federal law. We assume no responsibility or obligation for the administration of Your Employee Benefit Plan or Your acts. We reserve the right to determine amounts payable under this Policy without regards to such acts.

J. ENDORSEMENTS: Any endorsements attached or subsequently issued by us shall become a part of this Policy.

K. ENTIRE AGREEMENT: This Policy and any attached endorsements, Your attached Application and your Plan Document are the entire agreement between You and Us. We have relied upon the underwriting information (including Complete Claims History and the Plan Document) provided by You in issuing this Policy and You represent such information is complete and accurate. Should We later learn such information was incomplete or incorrect, We have the right to modify the Policy as of the effective date to reflect the complete or correct information or to terminate the Policy.

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L. INDEMNIFICATION, DEFENSE AND HOLD HARMLESS: You agree to indemnify, defend and hold Us harmless from any liability, including but not limited to, interest, penalties, attorney fees, extra contractual, exemplary or punitive damages ("expenses") arising from or relating to:

1. Any negligence, error, omission, defalcation or intentional acts by your Plan Supervisor, or

2. Any dispute involving Covered Person(s), former Covered Person(s), or any person(s) claiming entitlement to benefits under the Employee Benefit Plan, or

3. Any taxes We are assessed with respect to funds paid to or by You under Your Employee Benefit Plan, except any taxes or amounts paid to Us as premiums for this Policy.

Deleted: State premium

We will promptly notify You upon discovery of matters to which Your obligations under this provision apply. We have the right to participate in the defense at Our expense. Without limiting the foregoing, if You fail to defend timely, We have the right, but not the duty, to defend and to compromise or settle the claim or other matters on Your behalf, for Your account and at Your risk.

M. INSOLVENCY: In the event of Your insolvency or bankruptcy, subject to the terms, conditions and limitations of this policy, We may pay to Your receiver, trustee, liquidator or legal successor amounts otherwise payable under this Policy. We will make such payments only if You have Paid all required premiums and have complied with Your obligations under this Policy. Nothing in this section shall increase Our liability beyond that which would have existed had You not become insolvent or bankrupt.

N. LEGAL ACTION: No legal action can be brought to recover under this Policy:

1. Until 60 days after the date a reimbursement claim is submitted, or

2. Two years after the date a reimbursement claim is required to be furnished. You shall notify Us in writing within 10 days after receipt of any objection, notice of legal action or complaint regarding Your handling of a claim.

O. NOTICE: Notice under this Policy will be given to You through Your Plan Supervisor and will be deemed to have been received by You.

P. OFFSET: We may offset payments due to You under this Policy against claims overpayments, cost containment charges and premiums due and unpaid.

Q. PAYMENT OF PREMIUMS:

1. Each premium is payable to HCC Life Insurance Company, P.O. Box 402032, Atlanta, GA 30384-2032 or such other place as We designate in writing.

2. Specific Stop Loss Insurance premiums are due on the first day of each calendar month, regardless of the effective date of the Policy. If the effective date is other than the first day of a calendar month, the first month's premium will be pro-rated.

3. Aggregate Stop Loss Premium(s) are due monthly or are payable in advance for the Policy Year, as stated in Your Application.

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4. A grace period of 31 days is allowed for the payment of each premium after the first premium. If the premium is not paid during the grace period, the Policy will terminate without further notice as of the premium due date.

5. If we terminate this Policy for non-payment of premium, application may be made for reinstatement.

   All outstanding premiums, including the current month's premium, must be remitted within 10 days of the end of the grace period.

   Payment of premiums shall not guarantee reinstatement of the Policy. We reserve the right to conduct a diligent review of the Complete Claims History and re-underwrite the Policy as We deem necessary as part of the terms for reinstatement.

   If the Policy is terminated more than one time during a Policy Year for non-payment, no requests for reinstatement will be granted.

6. In no event, will more than three (3) months of retroactive credit be granted for any clerical error(s) in the remittance of any premium.

R. POLICY NON-PARTICIPATING: This Policy is non-participating and does not entitle You to share in Our earnings.

S. RECORDS: You and / or Your Plan Supervisor will maintain such records as may be required by Us for this Policy and will make them available to us upon Our request. These records may include, but are not limited to, the Complete Claims History. We may audit Your records relating to this Policy and the claims filed under the Employee Benefit Plan at any time during the Policy Year and for two years after the expiration date of such Policy. Your records will include records held by You or by Your Plan Supervisor. As a result of any audit, We may readjust your Monthly Specific Premium Rates, Monthly Aggregate Factors, premiums, deductibles or expenses as may be necessary to reflect Our original intent in underwriting this Policy.

T. RENEWAL: Unless terminated for any of the reason(s) described in this Policy, Your insurance will be renewed for another Policy Year if You accept Our renewal terms. We will not change rates more than once in any Policy Year, except as allowed under the Changes and Termination Provisions in Article VII.

We reserve the right to change the renewal premium rates and Monthly Aggregate Factors for the new Contract Period if the average monthly payments made by You for Plan Benefits during the last two months of the current Policy Year vary by more than 30% from the average of the monthly payments made for Plan Benefits during the previous ten (10) Contract Months.

We will not offer a renewal if We are no longer doing business with Your Plan Supervisor.

U. SUBSIDIARIES AND AFFILIATED COMPANIES: You must notify Us in the event You acquire a subsidiary or affiliated company that will be included under Your Employee Benefit Plan. If You do acquire a subsidiary or affiliated company that will be included under Your Employee Benefit Plan, You must disclose certain claims information on the acquired subsidiary as a whole and / or on persons whose coverage You will be assuming under Your Employee Benefit Plan. Failure to do so will subject benefits under this Policy to certain limitations, as described under the ENTIRE AGREEMENT provision of this Article.

Acquisition of a subsidiary or affiliated company that will be included under Your Employee Benefit Plan may affect Your Monthly Specific Premium Rates and/or Monthly Aggregate Factors, as described in the CHANGES AND TERMINATIONS provision of this Article.

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You must notify Us in the event You cede or dissolve a subsidiary or affiliated company that was included under your Employee Benefit Plan. Failure to do so may subject this Policy to termination or may affect Your Monthly Specific Premium Rates and/or Monthly Aggregate Factors as described in the CHANGES AND TERMINATIONS provision of this Article.

V. TAXES: You shall hold Us harmless from any taxes, which may be assessed against Us with respect to Your Employee Benefit Plan or with respect to claims for Covered Expenses paid under the Policy, and You shall reimburse Us for such taxes, if any, as determined by Us.

Deleted: state premium

Deleted: Plan Benefits paid under the

Deleted: Covered Expenses

W. YOUR DESIGNATED PLAN SUPERVISOR (YOUR TPA). We agree to recognize Your Plan Supervisor as Your agent and attorney-in-fact for the administration of Your Employee Benefit Plan. You agree that:

1. Your Plan Supervisor is Your agent and attorney-in-fact, and is not Our agent. You authorize Your Plan Supervisor to act in Your name, place and stead for purposes of this Policy, to include submission of proofs of loss, certifying the Payment of Plan Benefits, transmitting reports and payments of premiums to Us and receiving reimbursements from Us. Payments sent by Us to Your Plan Supervisor are payments to You. Premium payments by You through Your Plan Supervisor will be payments to Us only to the extent We actually receive them.

2. You or Your Plan Supervisor is responsible for administering Your Employee Benefit Plan, preparing reports as required by Us and keeping and making available to Us such data as We may require.

3. You or Your Plan Supervisor will perform such duties and keep such records as are required for You to comply with this Policy.

4. You will pay Your Plan Supervisor for all administrative functions performed in relation to this Policy.

5. We reserve the right to cease doing business with Your Plan Supervisor.

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SERFF Tracking Number:	*HCCH-126714556*	*State:*	*Arkansas*
Filing Company:	*HCC Life Insurance Company*	*State Tracking Number:*	*46167*
Company Tracking Number:	*PPACA HCCL MSL-2010*		
TOI:	*H12 Health - Excess/Stop Loss*	*Sub-TOI:*	*H12.004 Self-Funded Health Plan*
Product Name:	*Medical Stop Loss*		
Project Name/Number:	*/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/09/2010	Form	Medical Stop Loss Application	07/20/2010	HCCL MSL-2010 APP - final.pdf (Superceded)
07/09/2010	Supporting Document	Application	07/20/2010	HCCL MSL-2010 APP - redline.pdf (Superceded)

STOP LOSS INSURANCE

HCC LIFE INSURANCE COMPANY

Three Town Park Commons, 225 TownPark Drive, Suite 145
Kennesaw, Georgia 30144 (800 447-0460)

APPLICATION

1. Full Legal Name of Applicant and Address

Telephone No.:

2. Applicant is a (check one)**:** ☐ Corporation ☐ Labor Union ☐ Partnership ☐ Association ☐ MEWA ☐ PEO ☐ Other:

3. Contract Period: Effective Date: Expiration Date:

4. Full Legal Name of Affiliates, Subsidiaries and other major locations to be included in coverage:

Address of Affiliates or Subsidiaries:
☐ None ☐ See attached listing

5. Nature of Business of the Applicant to be Insured:

6. Key Contact Person at Applicant:

7. Enter full name of the Employee Benefit Plan(s):

A signed copy of such Employee Benefit Plan(s) must be attached and will form part of this contract.

8. Name and Address of Plan Supervisor:

9. Agent of Record:

10. Estimated Initial Enrollment. Single: Family: Total Covered Units:

11. Retirees Covered: ☐ Yes ☐ No

12. The Utilization Review vendor will be:

13. Deposit Premium (Minimum of first month's estimated premium)**:** $
Please review the deposit premium on the Monthly Premium Accounting Worksheet.

14. SPECIFIC STOP LOSS INSURANCE: ☐ Yes ☐ No

A. Covered Expenses Paid under the Employee Benefit Plan for the following Plan Benefits are covered for Specific Stop Loss Insurance (not included unless checked):
☐ Medical ☐ Prescription Drug Card ☐ Prescription Drugs Under Medical ☐ Other:

B. Specific Deductible in each Contract Period per Covered Person or per Covered Family: $

C. Contract Basis:
Covered Expenses **Incurred** from [Date] through [Date] and **Paid** from [Date] through [Date]

D. [Unlimited Specific Lifetime Reimbursement Maximum per Covered Person or Covered Family]
[Specific Contract Period Reimbursement Maximum per Covered Person or Covered Family: $]

E. Separate Individual Specific Deductible:
[Name] for [Amount]

F. Monthly Specific Premium Rates: Single: $ Family: $

G. Specific Percentage Reimbursable _____%

H. Specific Terminal Liability Option: ☐ Yes ☐ No
Specific Terminal Liability Option premium per Covered Person per month: $

Applicant's Initials:_____

15. AGGREGATE STOP LOSS INSURANCE: ☐ Yes ☐ No

A. Covered Expenses Paid under the Employee Benefit Plan for the following Plan Benefits are covered for Aggregate Stop Loss Insurance (not included unless checked):
☐ Medical ☐ Dental ☐ Weekly Income ☐ Vision ☐ Prescription Drug Card
☐ Prescription Drugs Under Medical ☐ Other:

B. Minimum Annual Aggregate Deductible: $
(Subject to the Definition of Minimum Annual Aggregate Deductible in the Policy)

C. Contract Basis:
Covered Expenses **Incurred** from [Date] through [Date], and **Paid** from [Date] through [Date].
Run-In claims limited to: $

D. Aggregate Contract Period Reimbursement Maximum: $

E. Monthly Aggregate Factors:

Monthly Factors	Combined	Medical	Dental	Weekly Income	Vision	Prescription Drugs
Composite						
Single						
Family						

F. Aggregate Percentage Reimbursable _____%

G. Loss Limit: $
For the purposes of Aggregate Stop Loss Insurance, the Loss Limit is the maximum amount of Covered Expenses Incurred by each Covered Person (or Covered Family), which can be used to satisfy the Annual Aggregate Deductible.

H. Monthly Deductible Advance Reimbursement Option: ☐ Yes ☐ No

I. Aggregate Terminal Liability Option: ☐ Yes ☐ No

J. Aggregate Premium:
1. ☐ Annual Premium payable in advance for Contract Period: $
2. ☐ Monthly Premium rate per Covered Unit: $
3. ☐ Monthly Deductible Advance Reimbursement premium per Covered Unit per month: $
4. ☐ Aggregate Terminal Liability Option premium per Covered Unit per month: $

SPECIAL LIMITATIONS:
Specific:

_____

_____

Aggregate:

_____

_____

It is understood and agreed by the Applicant that:

1. The Applicant is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan, and
2. The Plan Supervisor retained by the Applicant will be considered the Applicant's Agent, and not the Company's Agent, and
3. All documentation requested by the Company must be received within 90 days of the Policy effective date, and is subject to approval by the Company and may require adjustment of rates, factors, and / or Special Limitations to accommodate for abnormal risks, and
4. The Stop Loss Insurance applied for herein will not become effective until accepted by the Company, and
5. Premiums are not considered paid until the premium check is received by the Company, is paid according to the rates set forth in the Application, and all items required to issue the Policy have been returned to the Company. Premiums are subject to refund should any outstanding policy requirement not be met within 90 days of the Policy's effective date, and
6. This Application will be attached to and made a part of the Policy issued by the Company, and
7. The Employee Benefit Plan(s) attached shall be the basis of any Stop Loss Insurance provided by the Company and such Employee Benefit Plan(s) conforms with all applicable State and Federal statutes, and
8. Any reimbursement under the Stop Loss Insurance provided by the Company shall be based on Covered Expenses Paid by the Applicant in accordance with the Employee Benefit Plan(s) attached hereto, and
9. After diligent and complete review, the representations made in this Application, the disclosures made, and all of the information provided for underwriters to evaluate the risk, are true and complete.

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Full Legal Name of Applicant: Applicant's Federal Tax I.D. Number:

Dated at _____ this _____ day of _____, 20_____.

_____ _____

Officer / Partner Signature (print name) Licensed Agent Signature (print name)

For HCC Life Insurance Company Use Only: ACCEPTANCE
Accepted on behalf of the Company, this ____ day of _____, 20____.

By:_____ Title: _____

Policy No.: _____

STOP LOSS INSURANCE
HCC LIFE INSURANCE COMPANY
Three Town Park Commons, 225 TownPark Drive, Suite 145
Kennesaw, Georgia 30144 (800 447-0460)
APPLICATION

1. Full Legal Name of Applicant and Address

Telephone No.:

2. Applicant is a (check one)**:** ☐ Corporation ☐ Labor Union ☐ Partnership ☐ Association ☐ MEWA ☐ PEO ☐ Other:

3. Contract Period: Effective Date: Expiration Date:

4. Full Legal Name of Affiliates, Subsidiaries and other major locations to be included in coverage:

Address of Affiliates or Subsidiaries:
☐ None ☐ See attached listing

5. Nature of Business of the Applicant to be Insured:

6. Key Contact Person at Applicant:

7. Enter full name of the Employee Benefit Plan(s):

A signed copy of such Employee Benefit Plan(s) must be attached and will form part of this contract.

8. Name and Address of Plan Supervisor:

9. Agent of Record:

10. Estimated Initial Enrollment. Single: Family: Total Covered Units:

11. Retirees Covered: ☐ Yes ☐ No

12. The Utilization Review vendor will be:

13. Deposit Premium (Minimum of first month's estimated premium)**:** $
Please review the deposit premium on the Monthly Premium Accounting Worksheet.

14. SPECIFIC STOP LOSS INSURANCE: ☐ Yes ☐ No

A. Covered Expenses Paid under the Employee Benefit Plan for the following Plan Benefits are covered for Specific Stop Loss Insurance (not included unless checked):
☐ Medical ☐ Prescription Drug Card ☐ Prescription Drugs Under Medical ☐ Other:

B. Specific Deductible in each Contract Period per Covered Person or per Covered Family: $

C. Contract Basis:
Covered Expenses **Incurred** from [Date] through [Date] and **Paid** from [Date] through [Date]

D. [Unlimited Specific Lifetime Reimbursement Maximum per Covered Person or Covered Family]
[Specific Contract Period Reimbursement Maximum per Covered Person or Covered Family: $]

Deleted: : $

E. Separate Individual Specific Deductible:
[Name] for [Amount]

F. Monthly Specific Premium Rates: Single: $ Family: $

G. Specific Percentage Reimbursable _____%

H. Specific Terminal Liability Option: ☐ Yes ☐ No
Specific Terminal Liability Option premium per Covered Person per month: $

Deleted: 07

15. AGGREGATE STOP LOSS INSURANCE: ☐ Yes ☐ No

A. Covered Expenses Paid under the Employee Benefit Plan for the following Plan Benefits are covered for Aggregate Stop Loss Insurance (not included unless checked):
☐ Medical ☐ Dental ☐ Weekly Income ☐ Vision ☐ Prescription Drug Card
☐ Prescription Drugs Under Medical ☐ Other:

B. Minimum Annual Aggregate Deductible: $
(Subject to the Definition of Minimum Annual Aggregate Deductible in the Policy)

C. Contract Basis:
Covered Expenses **Incurred** from [Date] through [Date], and **Paid** from [Date] through [Date].
Run-In claims limited to: $

D. Aggregate Contract Period Reimbursement Maximum: $

E. Monthly Aggregate Factors:

Monthly Factors	Combined	Medical	Dental	Weekly Income	Vision	Prescription Drugs
Composite						
Single						
Family						

F. Aggregate Percentage Reimbursable _____%

G. Loss Limit: $
For the purposes of Aggregate Stop Loss Insurance, the Loss Limit is the maximum amount of Covered Expenses Incurred by each Covered Person (or Covered Family), which can be used to satisfy the Annual Aggregate Deductible.

H. Monthly Deductible Advance Reimbursement Option: ☐ Yes ☐ No

I. Aggregate Terminal Liability Option: ☐ Yes ☐ No

J. Aggregate Premium:
1. ☐ Annual Premium payable in advance for Contract Period: $
2. ☐ Monthly Premium rate per Covered Unit: $
3. ☐ Monthly Deductible Advance Reimbursement premium per Covered Unit per month: $
4. ☐ Aggregate Terminal Liability Option premium per Covered Unit per month: $

Deleted: 07

SPECIAL LIMITATIONS:
Specific:

_____

_____
Aggregate:

_____

_____
It is understood and agreed by the Applicant that:

1. The Applicant is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan, and
2. The Plan Supervisor retained by the Applicant will be considered the Applicant's Agent, and not the Company's Agent, and
3. All documentation requested by the Company must be received within 90 days of the Policy effective date, and is subject to approval by the Company and may require adjustment of rates, factors, and / or Special Limitations to accommodate for abnormal risks, and
4. The Stop Loss Insurance applied for herein will not become effective until accepted by the Company, and
5. Premiums are not considered paid until the premium check is received by the Company, is paid according to the rates set forth in the Application, and all items required to issue the Policy have been returned to the Company. Premiums are subject to refund should any outstanding policy requirement not be met within 90 days of the Policy's effective date, and
6. This Application will be attached to and made a part of the Policy issued by the Company, and
7. The Employee Benefit Plan(s) attached shall be the basis of any Stop Loss Insurance provided by the Company and such Employee Benefit Plan(s) conforms with all applicable State and Federal statutes, and
8. Any reimbursement under the Stop Loss Insurance provided by the Company shall be based on Covered Expenses Paid by the Applicant in accordance with the Employee Benefit Plan(s) attached hereto, and
9. After diligent and complete review, the representations made in this Application, the disclosures made, and all of the information provided for underwriters to evaluate the risk, are true and complete.

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Full Legal Name of Applicant: Applicant's Federal Tax I.D. Number:

Dated at _____ this _____ day of _____, 20_____.

_____ _____
Officer / Partner Signature (print name) Licensed Agent Signature (print name)

For HCC Life Insurance Company Use Only: ACCEPTANCE
Accepted on behalf of the Company, this ____ day of _____, 20____.

By:_____ Title: _____

Policy No.: _____

Deleted: 07